

**ST. VINCENT JENNINGS HOSPITAL
NORTH VERNON, INDIANA**

PROVIDER NOS. 15-1303, 15-Z303 AND AIM NO. 200360180

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

JUNE 30, 2012

ST. VINCENT JENNINGS HOSPITAL

PROVIDER NOS. 15-1303, 15-Z303 AND AIM NO. 200360180

TABLE OF CONTENTS

Accountants' Disclaimer

Hospital Statements of Reimbursable Costs



Bradley Associates
Healthcare Advisors and CPAs

Board of Directors
St. Vincent Jennings Hospital
North Vernon, Indiana

In accordance with your request, we have compiled the Hospital Statements of Reimbursable Costs (Titles XVIII and XIX) of St. Vincent Jennings Hospital (Provider Nos. 15-1303, 15-Z303 and AIM No. 200360180) 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 26, 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).
 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

Provider CCN: 151303	Period: From 07/01/2011 To 06/30/2012	Worksheet S Parts I-III Date/Time Prepared: 11/26/2012 2:57 pm
----------------------	---------------------------------------	--

PART I - COST REPORT STATUS

Provider use only: 1. Electronically filed cost report Date: 11/26/2012 Time: 2:57 pm
 2. Manually submitted cost report
 3. If this is an amended report enter the number of times the provider resubmitted this cost report
 4. Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only: 5. Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended
 6. Date Received: 7. Contractor No. 8. Initial Report for this Provider CCN 9. Final Report for this Provider CCN
 10. NPR Date: 11. Contractor's Vendor Code: 4 12. If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST. VINCENT JENNINGS 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: 11/26/2012 Time: 2:57 pm
 FVYw5TO4BwiKEeJedHJrheCH4THH90
 fntkr0MtMqo8h:0r3bq1wUEY7XmkM
 Drev0UFN5tOpMuQ1
 PI: Date: 11/26/2012 Time: 2:57 pm
 nWmwKDujANLZg81bpiitiI40zoQF0
 M:7Jz0CnbbAceytG1HyhAvnJ1DEDVH
 K3E9VDTVlM0ufj.0

(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	42,583	-631,020	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	66,735	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	109,318	-631,020	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: 151303		Period: From 07/01/2011 To 06/30/2012		Worksheet S-2 Part I Date/Time Prepared: 11/26/2012 11:29 am					
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 301 HENRY STREET		PO Box:							1.00	
2.00	City: NORTH VERNON		State: IN		Zip Code: 47265		County: JENNINGS			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 JENNINGS HOSPITAL	151303	99915	1	07/01/1996	N	O	P	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 JENNINGS SWING BED	152303	99915		07/05/1991	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							N	N	N	13.00
14.00	Hospital-Based Hospice										14.00
15.00	Hospital-Based Health Clinic - RHC							N	N	N	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	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	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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151303	Period: From 07/01/2011 To 06/30/2012	Worksheet S-2 Part I Date/Time Prepared: 11/26/2012 11:29 am			
		Beginning: 1.00		Ending: 2.00			
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
		V	XVIII	XIX			
		1.00	2.00	3.00			
Prospective Payment System (PPS)-Capital							
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR section §412.320? (see instructions)	N	N	N		45.00	
46.00	Is this facility eligible for 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		61.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)							
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00				62.00	
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00				62.01	
Teaching Hospitals that Claim Residents in Non-Provider Settings							
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)	N				63.00	
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))			
		1.00	2.00	3.00			
Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.							
64.00	If line 63 is yes or your facility trained residents in the base year period, enter in column 1, from your cost reporting period that begins on or after July 1, 2009, and before June 30, 2010 the number of unweighted nonprimary care FTE residents attributable to rotations that occurred in all nonprovider settings. Enter in column 2 the number of unweighted nonprimary care FTE residents that trained in your hospital. Include unweighted OB/GYN, dental and podiatry FTEs on this line. Enter in column 3, the ratio of column 1 divided by the sum of columns 1 and 2.	0.00	0.00	0.000000		64.00	
		Program Name	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	
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151303	Period: From 07/01/2011 To 06/30/2012	Worksheet S-2 Part I Date/Time Prepared: 11/26/2012 11:29 am		
		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			N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.				N	92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N			N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N			N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.		0.00		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	Y	N	109.00
				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	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151303	Period: From 07/01/2011 To 06/30/2012	Worksheet S-2 Part I Date/Time Prepared: 11/26/2012 11:29 am			
		1.00	2.00	3.00			
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	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.	12,361	0	0			118.01
		1.00	2.00				
118.02	Indicate if malpractice premiums and paid losses are reported in other than the Administrative and General cost center. If yes, provide a supporting schedule and list the amounts applicable to each cost center.	N					118.02
119.00	DO NOT USE THIS LINE						119.00
120.00	If this is an SCH (or EACH), regardless of bed size, or is rural hospital with 100 or fewer beds that qualifies for the outpatient hold harmless provision in accordance with ACA, section 3121, as amended by the Medicare and Medicaid Extenders Act (MMEA) of 2010, section 108; the Temporary Payroll Tax Cut Continuation Act of 2011, section 308; and the Middle Class Tax Relief and Job Creation Act of 2012, section 3002, enter "Y" for yes or "N" for no in column 1 or column 2, respectively. Note that for SCHs (and EACHs) the outpatient hold harmless provision is effective for services rendered from January 1, 2010 through February 29, 2012 regardless of bed size and from March 1, 2012 through December 31, 2012 to all SCHs (and EACHs) with 100 or fewer beds. These responses impact the TOPS calculation on Worksheet E, Part B, line 8.	N		N			120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y					121.00
Transplant Center Information							
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N					125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.						134.00
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		15HO46			140.00
		1.00	2.00	3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name: ST. VINCENT HEALTH	Contractor's Name: WPS		Contractor's Number: 08101			141.00
142.00	Street: 10330 N. MERIDAN ST	PO Box:					142.00
143.00	City: INDIANAPOLIS	State: IN		Zip Code: 46290			143.00
				1.00			
144.00	Are provider based physicians' costs included in worksheet A?	Y					144.00
145.00	If costs for renal services are claimed on worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.	N					145.00
				1.00			
				2.00			
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N					146.00
147.00	was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N					147.00
148.00	was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N					148.00
149.00	was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N					149.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151303		Period: From 07/01/2011 To 06/30/2012		Worksheet S-2 Part I Date/Time Prepared: 11/26/2012 11:29 am		
		Part A	Part B	Title V	Title XIX			
		1.00	2.00	3.00	4.00			
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)								
155.00	Hospital	N	N	N	N		155.00	
156.00	Subprovider - IPF	N	N	N	N		156.00	
157.00	Subprovider - IRF	N	N	N	N		157.00	
158.00	SUBPROVIDER						158.00	
159.00	SNF	N	N	N	N		159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N		160.00	
161.00	CMHC		N	N	N		161.00	
						1.00		
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	166.00
						1.00		
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act								
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.						N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)							0168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)							0.00169.00

		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.		Y	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

		Part A		
Description		Y/N	Date	
0		1.00	2.00	
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	Y		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.	Y		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.	Y		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

Cost Center Description		Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	
		1.00	2.00	3.00	4.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	25	9,150	21,888.00	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	21,888.00	7.00
8.00	INTENSIVE CARE UNIT	31.00	0	0	0.00	8.00
9.00	CORONARY CARE UNIT					9.00
10.00	BURN INTENSIVE CARE UNIT	33.00	0	0	0.00	10.00
11.00	SURGICAL INTENSIVE CARE UNIT					11.00
12.00	OTHER SPECIAL CARE (SPECIFY)					12.00
13.00	NURSERY					13.00
14.00	Total (see instructions)		25	9,150	21,888.00	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.)	115.00				23.00
24.00	HOSPICE	116.00	0	0		24.00
25.00	CMHC - CMHC					25.00
26.00	RURAL HEALTH CLINIC	88.00				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	586	142	912		1.00
2.00 HMO		82	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	448	0	448		5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0		0	99		6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	0	1,034	142	1,459		7.00
8.00 INTENSIVE CARE UNIT	0	0	0	0		8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT	0	0	0	0		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	1,034	142	1,459		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		0	0	0		24.00
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0	0	0	0		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	385		28.00
29.00 Ambulance Trips		0				29.00
30.00 Employee discount days (see instruction)				0		30.00
31.00 Employee discount days - IRF				0		31.00
32.00 Labor & delivery days (see instructions)			0	0		32.00
33.00 LTCH non-covered days		0				33.00

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	211	1.00
2.00 HMO					25	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	125.17	0.00	0	211	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.)	0.00	0.00	0.00			23.00
24.00 HOSPICE	0.00	0.00	0.00			24.00
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0.00	0.00	0.00			26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)	0.00	125.17	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)	29	336		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)	29	336		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

		1.00		
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part 1 line 200 column 3 divided by line 200 column 8) Medicaid (see instructions for each line)	0.323681		1.00
2.00	Net revenue from Medicaid	2,108,203		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?			3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?			4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0		5.00
6.00	Medicaid charges	9,797,991		6.00
7.00	Medicaid cost (line 1 times line 6)	3,171,424		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)	1,063,221		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	273,389		18.00
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	1,063,221		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	6,145,159	2,644	6,147,803
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	1,989,071	856	1,989,927
22.00	Partial payment by patients approved for charity care	0	0	0
23.00	Cost of charity care (line 21 minus line 22)	1,989,071	856	1,989,927
				1.00
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit		0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		1,927,265	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		278,655	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)		1,648,610	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)		533,624	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)		2,523,551	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		3,586,772	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151303

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

Worksheet A

Date/Time Prepared:
11/26/2012 11:29 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100		808,334	808,334	-48,986	759,348	1.00
2.00	00200		0	0	0	0	2.00
3.00	00300		0	0	0	0	3.00
4.00	00400	123,690	1,922,694	2,046,384	-10	2,046,374	4.00
5.00	00500	1,602,958	2,129,369	3,732,327	47,970	3,780,297	5.00
6.00	00600	0	0	0	0	0	6.00
7.00	00700	142,849	632,233	775,082	0	775,082	7.00
8.00	00800	0	95,215	95,215	0	95,215	8.00
9.00	00900	167,788	158,609	326,397	-1,786	324,611	9.00
10.00	01000	159,870	83,876	243,746	-178,969	64,777	10.00
11.00	01100	0	0	0	178,520	178,520	11.00
12.00	01200	0	0	0	0	0	12.00
13.00	01300	189,138	25,763	214,901	0	214,901	13.00
14.00	01400	68,094	25,058	93,152	-1,339	91,813	14.00
15.00	01500	158,314	388,912	547,226	-141	547,085	15.00
16.00	01601	125,339	58,563	183,902	-37	183,865	16.00
17.00	01700	0	0	0	0	0	17.00
18.00	01850	0	0	0	0	0	18.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	966,266	411,514	1,377,780	-29,250	1,348,530	30.00
31.00	03100	0	0	0	0	0	31.00
33.00	03300	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	395,483	261,871	657,354	-8,131	649,223	50.00
51.00	05100	0	0	0	0	0	51.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	827,428	933,347	1,760,775	-32,181	1,728,594	54.00
55.00	05500	0	0	0	0	0	55.00
56.00	05600	0	0	0	0	0	56.00
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	0	1,169,879	1,169,879	-22,444	1,147,435	60.00
60.01	06001	0	0	0	0	0	60.01
61.00	06100	0	0	0	0	0	61.00
62.00	06200	0	0	0	0	0	62.00
63.00	06300	0	0	0	0	0	63.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	0	18,773	18,773	-3,353	15,420	65.00
66.00	06600	0	226,684	226,684	-3,232	223,452	66.00
67.00	06700	0	36,207	36,207	-15	36,192	67.00
68.00	06800	0	3,393	3,393	0	3,393	68.00
69.00	06900	0	12,900	12,900	22,220	35,120	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	174,198	174,198	156,832	331,030	71.00
72.00	07200	0	226,613	226,613	0	226,613	72.00
73.00	07300	0	0	0	0	0	73.00
74.00	07400	0	0	0	0	0	74.00
75.00	07500	0	0	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	860	860	0	860	88.00
91.00	09100	1,184,023	873,358	2,057,381	-75,668	1,981,713	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	04040	0	0	0	0	0	93.00
SPECIAL PURPOSE COST CENTERS							
115.00	11500	0	0	0	0	0	115.00
116.00	11600	0	0	0	0	0	116.00
118.00		6,111,240	10,678,223	16,789,463	0	16,789,463	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	0	0	0	0	0	192.00
193.00	19300	0	0	0	0	0	193.00
194.00	07950	147,985	73,552	221,537	0	221,537	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	9,253	800	10,053	0	10,053	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07955	0	0	0	0	0	194.04
200.00		6,268,478	10,752,575	17,021,053	0	17,021,053	200.00

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
		6.00	7.00	
GENERAL SERVICE COST CENTERS				
1.00	00100 CAP REL COSTS-BLDG & FIXT	-9,039	750,309	1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	0	0	2.00
3.00	00300 OTHER CAP RELATED COST	0	0	3.00
4.00	00400 EMPLOYEE BENEFITS	-68,325	1,978,049	4.00
5.00	00500 ADMINISTRATIVE & GENERAL	-30,117	3,750,180	5.00
6.00	00600 MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700 OPERATION OF PLANT	-8,693	766,389	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	95,215	8.00
9.00	00900 HOUSEKEEPING	52,971	377,582	9.00
10.00	01000 DIETARY	-50,872	13,905	10.00
11.00	01100 CAFETERIA	0	178,520	11.00
12.00	01200 MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300 NURSING ADMINISTRATION	0	214,901	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	91,813	14.00
15.00	01500 PHARMACY	0	547,085	15.00
16.00	01601 MEDICAL RECORDS & LIBRARY	-13,372	170,493	16.00
17.00	01700 SOCIAL SERVICE	0	0	17.00
18.00	01850 OTHER GENERAL SERVICE (SPECIFY)	0	0	18.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS	-210,988	1,137,542	30.00
31.00	03100 INTENSIVE CARE UNIT	0	0	31.00
33.00	03300 BURN INTENSIVE CARE UNIT	0	0	33.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	649,223	50.00
51.00	05100 RECOVERY ROOM	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY - DIAGNOSTIC	-1,485	1,727,109	54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	0	0	55.00
56.00	05600 RADIOISOTOPE	0	0	56.00
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000 LABORATORY	0	1,147,435	60.00
60.01	06001 BLOOD LABORATORY	0	0	60.01
61.00	06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	15,420	65.00
66.00	06600 PHYSICAL THERAPY	0	223,452	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	36,192	67.00
68.00	06800 SPEECH PATHOLOGY	0	3,393	68.00
69.00	06900 ELECTROCARDIOLOGY	-12,900	22,220	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	331,030	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	226,613	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	75.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC	-860	0	88.00
91.00	09100 EMERGENCY	-445,725	1,535,988	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
93.00	04040 FAMILY PRACTICE	0	0	93.00
SPECIAL PURPOSE COST CENTERS				
115.00	11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0	115.00
116.00	11600 HOSPICE	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	-799,405	15,990,058	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	190.00
191.00	19100 RESEARCH	0	0	191.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	192.00
193.00	19300 NONPAID WORKERS	0	0	193.00
194.00	07950 OTHER NONREIMBURSABLE COST CENTERS	0	221,537	194.00
194.01	07951 TOBACCO / CHILD GRANT	0	0	194.01
194.02	07952 OUTPATIENT CLINICS	0	10,053	194.02
194.03	07953 OTHER NONREIMBURSABLE COST CENTERS	230,590	230,590	194.03
194.04	07955 SPN	0	0	194.04
200.00	TOTAL (SUM OF LINES 118-199)	-568,815	16,452,238	200.00

		Increases				
		Cost Center	Line #	Salary	Other	
		2.00	3.00	4.00	5.00	
A - CAFETERIA						
1.00	CAFETERIA		11.00	117,089	61,431	1.00
	TOTALS			117,089	61,431	
B - INTEREST						
1.00	ADMINISTRATIVE & GENERAL		5.00	0	48,986	1.00
	TOTALS			0	48,986	
C - ELECTROCARDIOLOGY						
1.00	ELECTROCARDIOLOGY		69.00	0	22,220	1.00
	TOTALS			0	22,220	
D - MEDICAL SUPPLIES CHARGED TO PATIENTS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS		71.00	0	156,832	1.00
2.00			0.00	0	0	2.00
3.00			0.00	0	0	3.00
4.00			0.00	0	0	4.00
5.00			0.00	0	0	5.00
6.00			0.00	0	0	6.00
7.00			0.00	0	0	7.00
8.00			0.00	0	0	8.00
9.00			0.00	0	0	9.00
10.00			0.00	0	0	10.00
11.00			0.00	0	0	11.00
12.00			0.00	0	0	12.00
13.00			0.00	0	0	13.00
14.00			0.00	0	0	14.00
15.00			0.00	0	0	15.00
	TOTALS			0	156,832	
500.00	Grand Total: Increases			117,089	289,469	500.00

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - CAFETERIA							
1.00	DIETARY	10.00	117,089	61,431	0		1.00
	TOTALS		117,089	61,431			
B - INTEREST							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	48,986	9		1.00
	TOTALS		0	48,986			
C - ELECTROCARDIOLOGY							
1.00	LABORATORY	60.00	0	22,220	0		1.00
	TOTALS		0	22,220			
D - MEDICAL SUPPLIES CHARGED TO PATIENTS							
1.00	EMPLOYEE BENEFITS	4.00	0	10	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	1,016	0		2.00
3.00	HOUSEKEEPING	9.00	0	1,786	0		3.00
4.00	DIETARY	10.00	0	449	0		4.00
5.00	CENTRAL SERVICES & SUPPLY	14.00	0	1,339	0		5.00
6.00	PHARMACY	15.00	0	141	0		6.00
7.00	MEDICAL RECORDS & LIBRARY	16.00	0	37	0		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	29,250	0		8.00
9.00	OPERATING ROOM	50.00	0	8,131	0		9.00
10.00	RADIOLOGY - DIAGNOSTIC	54.00	0	32,181	0		10.00
11.00	LABORATORY	60.00	0	224	0		11.00
12.00	RESPIRATORY THERAPY	65.00	0	3,353	0		12.00
13.00	PHYSICAL THERAPY	66.00	0	3,232	0		13.00
14.00	OCCUPATIONAL THERAPY	67.00	0	15	0		14.00
15.00	EMERGENCY	91.00	0	75,668	3		15.00
	TOTALS		0	156,832			
500.00	Grand Total: Decreases		117,089	289,469			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151303

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
11/26/2012 11:29 am

	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	127,944	0	0	0	1.00
2.00	Land Improvements	400,829	0	0	0	2.00
3.00	Buildings and Fixtures	13,545,341	103,284	0	103,284	3.00
4.00	Building Improvements	0	0	0	0	4.00
5.00	Fixed Equipment	4,025,638	175,638	0	175,638	5.00
6.00	Movable Equipment	0	0	0	0	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	18,099,752	278,922	0	278,922	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	18,099,752	278,922	0	278,922	10.00
SUMMARY OF CAPITAL						
Cost Center Description		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)
		9.00	10.00	11.00	12.00	13.00
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	808,334	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	808,334	0	0	0	3.00
COMPUTATION OF RATIOS						
Cost Center Description		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance
		1.00	2.00	3.00	4.00	5.00
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	18,332,505	0	18,332,505	1.000000	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	2.00
3.00	Total (sum of lines 1-2)	18,332,505	0	18,332,505	1.000000	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151303

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
11/26/2012 11:29 am

		Ending Balance	Fully Depreciated Assets			
		6.00	7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	127,944	0			1.00
2.00	Land Improvements	400,829	0			2.00
3.00	Buildings and Fixtures	13,648,625	0			3.00
4.00	Building Improvements	0	0			4.00
5.00	Fixed Equipment	4,201,276	0			5.00
6.00	Movable Equipment	0	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	18,378,674	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	18,378,674	0			10.00
SUMMARY OF CAPITAL						
Cost Center Description		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)			
		14.00	15.00			
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	808,334			1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0			2.00
3.00	Total (sum of lines 1-2)	0	808,334			3.00
ALLOCATION OF OTHER CAPITAL						
Cost Center Description		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL Depreciation	Lease
		6.00	7.00	8.00	9.00	10.00
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	750,309	0 1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0 2.00
3.00	Total (sum of lines 1-2)	0	0	0	750,309	0 3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151303

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
11/26/2012 11:29 am

Cost Center Description	SUMMARY OF CAPITAL					Total (2) (sum of cols. 9 through 14)	
	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
	11.00	12.00	13.00	14.00	15.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	750,309	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	750,309	3.00

Line #	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on worksheet A To/From which the Amount is to be Adjusted			
				Cost Center		Line #	
				1.00	2.00	3.00	4.00
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	A	-172,800	CAP REL COSTS-BLDG & FIXT		1.00	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP		2.00	2.00
3.00	Investment income - other (chapter 2)	A	-23,852	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)		0			0.00	7.00
8.00	Television and radio service (chapter 21)	A	-5,140	OPERATION OF PLANT		7.00	8.00
9.00	Parking lot (chapter 21)		0			0.00	9.00
10.00	Provider-based physician adjustment	A-8-2	-683,828				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	384,377				12.00
13.00	Laundry and linen service		0			0.00	13.00
14.00	Cafeteria-employees and guests	B	-23,857	DIETARY		10.00	14.00
15.00	Rental of quarters to employee and others		0			0.00	15.00
16.00	Sale of medical and surgical supplies to other than patients		0			0.00	16.00
17.00	Sale of drugs to other than patients		0			0.00	17.00
18.00	Sale of medical records and abstracts	B	-13,372	MEDICAL RECORDS & LIBRARY		16.00	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0			0.00	19.00
20.00	Vending machines	B	-310	ADMINISTRATIVE & GENERAL		5.00	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0			0.00	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0			0.00	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY		65.00	23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY		66.00	24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***		114.00	25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT		1.00	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP		2.00	27.00
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	GAIN/LOSS OTHER	A	7,552	ADMINISTRATIVE & GENERAL		5.00	33.00
33.01	MISC REVENUE	B	-24	EMPLOYEE BENEFITS		4.00	33.01
33.02	MISC REVENUE	B	-15,864	ADMINISTRATIVE & GENERAL		5.00	33.02
33.03	MISC REVENUE	B	-27,015	DIETARY		10.00	33.03
33.06	RHC DEPRECIATION	A	-860	RURAL HEALTH CLINIC		88.00	33.06
33.07	SPN HOUSEKEEPING	A	69,300	HOUSEKEEPING		9.00	33.07
33.08	PHYSICIAN HOUSEKEEPING	A	-16,320	HOUSEKEEPING		9.00	33.08
33.09	PHYSICIAN PLANT OPS	A	-9,301	OPERATION OF PLANT		7.00	33.09
33.10	PHYSICIAN BENEFITS	A	-3,049	EMPLOYEE BENEFITS		4.00	33.10
33.14	CHARITABLE EXPENSE	A	-1,944	RADIOLOGY - DIAGNOSTIC		54.00	33.14
33.15	CHARITABLE EXPENSE	A	-107	ADULTS & PEDIATRICS		30.00	33.15
33.16	AHA & IHA DUES	A	-599	ADMINISTRATIVE & GENERAL		5.00	33.16
33.17	PAYROLL INCENTIVE	A	-16,312	ADMINISTRATIVE & GENERAL		5.00	33.17
33.18	DONATION EXPENSE	A	-969	ADMINISTRATIVE & GENERAL		5.00	33.18
33.19	CHARITABLE EXPENSE	A	-300	EMPLOYEE BENEFITS		4.00	33.19
33.20	CHARITABLE EXPENSE	A	-14,212	ADMINISTRATIVE & GENERAL		5.00	33.20
33.21	CHARITABLE EXPENSE	A	-9	HOUSEKEEPING		9.00	33.21
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200.)		-568,815				50.00

Cost Center Description		Wkst. A-7 Ref.	
		5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	9	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	0	2.00
3.00	Investment income - other (chapter 2)	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	0	7.00
8.00	Television and radio service (chapter 21)	0	8.00
9.00	Parking lot (chapter 21)	0	9.00
10.00	Provider-based physician adjustment	0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	0	11.00
12.00	Related organization transactions (chapter 10)	0	12.00
13.00	Laundry and linen service	0	13.00
14.00	Cafeteria-employees and guests	0	14.00
15.00	Rental of quarters to employee and others	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	0	16.00
17.00	Sale of drugs to other than patients	0	17.00
18.00	Sale of medical records and abstracts	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)	0	19.00
20.00	Vending machines	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	0	26.00
27.00	Depreciation - 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	GAIN/LOSS OTHER	0	33.00
33.01	MISC REVENUE	0	33.01
33.02	MISC REVENUE	0	33.02
33.03	MISC REVENUE	0	33.03
33.06	RHC DEPRECIATION	0	33.06
33.07	SPN HOUSEKEEPING	0	33.07
33.08	PHYSICIAN HOUSEKEEPING	0	33.08
33.09	PHYSICIAN PLANT OPS	0	33.09
33.10	PHYSICIAN BENEFITS	0	33.10
33.14	CHARITABLE EXPENSE	0	33.14
33.15	CHARITABLE EXPENSE	0	33.15
33.16	AHA & IHA DUES	0	33.16
33.17	PAYROLL INCENTIVE	0	33.17
33.18	DONATION EXPENSE	0	33.18
33.19	CHARITABLE EXPENSE	0	33.19
33.20	CHARITABLE EXPENSE	0	33.20
33.21	CHARITABLE EXPENSE	0	33.21
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: 151303

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

Worksheet A-8-1

Date/Time Prepared:
11/26/2012 11:29 am

	Line No.	Cost Center	Expense Items	
	1.00	2.00	3.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	2.00
3.00	4.00	EMPLOYEE BENEFITS	HOME OFFICE	3.00
4.00	194.03	OTHER NONREIMBURSABLE COST CENTERS	HOME OFFICE	4.00
4.01	1.00	CAP REL COSTS-BLDG & FIXT	ASCENSION - INTEREST	4.01
4.02	5.00	ADMINISTRATIVE & GENERAL	ASCENSION - INTEREST	4.02
4.03	1.00	CAP REL COSTS-BLDG & FIXT	ASCENSION - CHARGEBACK	4.03
4.04	5.00	ADMINISTRATIVE & GENERAL	ASCENSION - CHARGEBACK	4.04
4.05	7.00	OPERATION OF PLANT	HOME OFFICE - TRIMEDX	4.05
4.06	5.00	ADMINISTRATIVE & GENERAL	ST. VINCENT HEALTH - CHAR	4.06
4.07	7.00	OPERATION OF PLANT	ST. VINCENT HEALTH - CHAR	4.07
4.08	14.00	CENTRAL SERVICES & SUPPLY	ST. VINCENT HEALTH - CHAR	4.08
4.09	16.00	MEDICAL RECORDS & LIBRARY	ST. VINCENT HEALTH - CHAR	4.09
4.10	54.00	RADIOLOGY - DIAGNOSTIC	ST. VINCENT HEALTH - CHAR	4.10
4.11	13.00	NURSING ADMINISTRATION	ST. VINCENT HEALTH - CHAR	4.11
4.12	91.00	EMERGENCY	ST. VINCENT HEALTH - CHAR	4.12
4.13	4.00	EMPLOYEE BENEFITS	ST. VINCENT HEALTH - CHAR	4.13
4.14	4.00	EMPLOYEE BENEFITS	SELF INSURANCE	4.14
4.15	50.00	OPERATING ROOM	ST. VINCENT HEALTH - CHAR	4.15
4.16	54.00	RADIOLOGY - DIAGNOSTIC	HOME OFFICE - TRIMEDX	4.16
4.17	4.00	EMPLOYEE BENEFITS	ASCENSION - PENSION	4.17
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to worksheet A-8, column 2, line 12.			5.00

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

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

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

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

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

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

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

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

Provider CCN: 151303

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

Worksheet A-8-1

Date/Time Prepared: 11/26/2012 11:29 am

	Amount of Allowable Cost	Amount Included in wks. A, column 5	Net Adjustments (col. 4 minus col. 5)*	wkst. A-7 Ref.	
	4.00	5.00	6.00	7.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	204,191	0	204,191	9	1.00
2.00	1,179,966	1,139,937	40,029	0	2.00
3.00	0	67,146	-67,146	0	3.00
4.00	230,590	0	230,590	0	4.00
4.01	314,465	354,895	-40,430	9	4.01
4.02	43,406	48,986	-5,580	0	4.02
4.03	13,898	13,898	0	9	4.03
4.04	14,683	14,683	0	0	4.04
4.05	58,066	52,318	5,748	0	4.05
4.06	1,034,814	1,034,814	0	0	4.06
4.07	121,169	121,169	0	0	4.07
4.08	23,507	23,507	0	0	4.08
4.09	63,207	63,207	0	0	4.09
4.10	17,211	17,211	0	0	4.10
4.11	15	15	0	0	4.11
4.12	18,859	18,859	0	0	4.12
4.13	248,069	248,069	0	0	4.13
4.14	897,591	895,397	2,194	0	4.14
4.15	300	300	0	0	4.15
4.16	149,312	134,531	14,781	0	4.16
4.17	122,714	122,714	0	0	4.17
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to worksheet A-8, column 2, line 12.	4,756,033	4,371,656	384,377	5.00

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

Related Organization(s) and/or Home Office			
Name	Percentage of Ownership	Type of Business	
4.00	5.00	6.00	
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:			

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

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

6.00	ST. VINCENT HEA	100.00	ADMINISTRATION	6.00
7.00	ASCENSION	100.00	ADMINISTRATION	7.00
8.00	ST. VINCENT HOS	100.00	HOSPITAL	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: 151303

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

Worksheet A-8-2

Date/Time Prepared:
11/26/2012 11:29 am

	1.00	2.00	3.00	4.00	
	1.00	2.00	3.00	4.00	
	1.00	2.00	3.00	4.00	
1.00	30.00	ADULTS & PEDIATRICS	210,881	210,881	1.00
2.00	54.00	RADIOLOGY - DIAGNOSTIC	14,322	14,322	2.00
3.00	69.00	ELECTROCARDIOLOGY	12,900	12,900	3.00
4.00	91.00	EMERGENCY	1,006,840	445,725	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			1,244,943	683,828	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151303

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

Worksheet A-8-2

Date/Time Prepared:
11/26/2012 11:29 am

	Provider Component	RCE Amount	Physician/Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	5.00	6.00	7.00	8.00	9.00	
1.00	0	0	0	0	0	1.00
2.00	0	0	0	0	0	2.00
3.00	0	0	0	0	0	3.00
4.00	561,115	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	561,115			0	0	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151303

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

Worksheet A-8-2

Date/Time Prepared:
11/26/2012 11:29 am

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151303

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

Worksheet A-8-2

Date/Time Prepared:
11/26/2012 11:29 am

	RCE	Adjustment	
	Disallowance		
	17.00	18.00	
1.00	0	210,881	1.00
2.00	0	14,322	2.00
3.00	0	12,900	3.00
4.00	0	445,725	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	683,828	200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 151303	Period: From 07/01/2011 To 06/30/2012	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/26/2012 11:29 am
--	----------------------	---	---

		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)					216	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)					42	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	1,584.00	1,855.00	0.00	0.00	9.00	
10.00	AHSEA (see instructions)	0.00	70.79	54.72	0.00	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)	35.40	35.40	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)					112,131	15.00	
16.00	Assistants (column 3, line 9 times column 3, line 10)					101,506	16.00	
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					213,637	17.00	
18.00	Aides (column 4, line 9 times column 4, line 10)					0	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)					213,637	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)					213,637	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)					7,646	24.00	
25.00	Assistants (line 4 times column 3, line 11)					1,149	25.00	
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					8,795	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)					1,419	27.00	
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					10,214	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)					10,214	33.00	
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00	
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00	
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE								
Standard Travel Expense								
36.00	Therapists (line 5 times column 2, line 11)					0	36.00	
37.00	Assistants (line 6 times column 3, line 11)					0	37.00	
38.00	Subtotal (sum of lines 36 and 37)					0	38.00	
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00	
Optional Travel Allowance and Optional Travel Expense								
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00	
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00	
42.00	Subtotal (sum of lines 40 and 41)					0	42.00	
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00	
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.								
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00	

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 151303	Period: From 07/01/2011 To 06/30/2012	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/26/2012 11:29 am
--	----------------------	---	---

		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)	70.79	54.72	0.00	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)						213,637	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))						10,214	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)						223,851	63.00
64.00	Total cost of outside supplier services (from your records)						218,361	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						8,795	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						1,419	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27						10,214	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						1,419	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						1,419	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

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 151303		Period: From 07/01/2011 To 06/30/2012		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/26/2012 11:29 am	
				Occupational 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)					157	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	399.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	67.11	0.00	0.00	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)	33.56	33.56	0.00			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)					26,777	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					26,777	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	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)					26,777	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)					67.11	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					52,346	22.00
23.00	Total salary equivalency (see instructions)					52,346	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)					5,269	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)					5,269	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)					864	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					6,133	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)					6,133	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

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 151303			Period: From 07/01/2011 To 06/30/2012		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/26/2012 11:29 am	
							Occupational Therapy	Cost
							1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)						0	45.00
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	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	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	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	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	0.00	51.00
DETERMINATION OF OVERTIME ALLOWANCE								
52.00	Adjusted hourly salary equivalency amount (see instructions)	67.11	0.00	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	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	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	0	56.00
							1.00	
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT								
57.00	Salary equivalency amount (from line 23)						52,346	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35)						6,133	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)						58,479	63.00
64.00	Total cost of outside supplier services (from your records)						36,168	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						5,269	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						864	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27						6,133	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						864	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						864	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

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 151303	Period: From 07/01/2011 To 06/30/2012	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/26/2012 11:29 am
--	----------------------	---	---

		Speech Pathology					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)						27 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	40.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	64.50	0.00	0.00	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)	32.25	32.25	0.00			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)						2,580 15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)						0 16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)						2,580 17.00
18.00	Aides (column 4, line 9 times column 4, line 10)						0 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)						2,580 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)						64.50 21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)						50,310 22.00
23.00	Total salary equivalency (see instructions)						50,310 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)						871 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)						871 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)						149 27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)						1,020 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)						1,020 33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)						0 34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)						0 35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)						0 36.00
37.00	Assistants (line 6 times column 3, line 11)						0 37.00
38.00	Subtotal (sum of lines 36 and 37)						0 38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)						0 39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)						0 40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)						0 41.00
42.00	Subtotal (sum of lines 40 and 41)						0 42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)						0 43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)						0 44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)						0 45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 151303	Period: From 07/01/2011 To 06/30/2012	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/26/2012 11:29 am
--	----------------------	---	---

	Speech Pathology	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)	64.50	0.00	0.00	0.00	0.00	52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0	0	53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	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	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)					50,310	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35)					1,020	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)					51,330	63.00
64.00	Total cost of outside supplier services (from your records)					3,393	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					871	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					149	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27					1,020	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					149	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					149	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 Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
		1.00	2.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	750,309	750,309			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	0	0			2.00
4.00 00400	EMPLOYEE BENEFITS	1,978,049	0	1,978,049		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	3,750,180	66,285	516,001	4,332,466	5.00
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00 00700	OPERATION OF PLANT	766,389	68,495	45,984	880,868	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	95,215	815	0	96,030	8.00
9.00 00900	HOUSEKEEPING	377,582	15,400	54,012	446,994	9.00
10.00 01000	DIETARY	13,905	7,593	13,772	35,270	10.00
11.00 01100	CAFETERIA	178,520	15,646	37,692	231,858	11.00
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00 01300	NURSING ADMINISTRATION	214,901	1,780	60,885	277,566	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	91,813	12,483	21,920	126,216	14.00
15.00 01500	PHARMACY	547,085	7,024	50,962	605,071	15.00
16.00 01601	MEDICAL RECORDS & LIBRARY	170,493	59,422	40,348	270,263	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	17.00
18.00 01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	18.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	1,137,542	70,393	311,048	1,518,983	30.00
31.00 03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
33.00 03300	BURN INTENSIVE CARE UNIT	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	649,223	55,937	127,309	832,469	50.00
51.00 05100	RECOVERY ROOM	0	0	0	0	51.00
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	1,727,109	45,331	266,355	2,038,795	54.00
55.00 05500	RADIOLOGY - THERAPEUTIC	0	0	0	0	55.00
56.00 05600	RADIOISOTOPE	0	0	0	0	56.00
57.00 05700	CT SCAN	0	0	0	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00 06000	LABORATORY	1,147,435	16,772	0	1,164,207	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	60.01
61.00 06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0	0	0	61.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	62.00
63.00 06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	63.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	15,420	0	0	15,420	65.00
66.00 06600	PHYSICAL THERAPY	223,452	18,145	0	241,597	66.00
67.00 06700	OCCUPATIONAL THERAPY	36,192	0	0	36,192	67.00
68.00 06800	SPEECH PATHOLOGY	3,393	0	0	3,393	68.00
69.00 06900	ELECTROCARDIOLOGY	22,220	2,134	0	24,354	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	331,030	0	0	331,030	71.00
72.00 07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	226,613	0	0	226,613	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	74.00
75.00 07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
91.00 09100	EMERGENCY	1,535,988	45,277	381,145	1,962,410	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
93.00 04040	FAMILY PRACTICE	0	0	0	0	93.00
SPECIAL PURPOSE COST CENTERS						
115.00 11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	115.00
116.00 11600	HOSPICE	0	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	15,990,058	508,932	1,927,433	15,698,065	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	3,882	0	3,882	190.00
191.00 19100	RESEARCH	0	0	0	0	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	8,483	0	8,483	192.00
193.00 19300	NONPAID WORKERS	0	0	0	0	193.00
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	221,537	0	47,637	269,174	194.00
194.01 07951	TOBACCO / CHILD GRANT	0	0	0	0	194.01
194.02 07952	OUTPATIENT CLINICS	10,053	79,787	2,979	92,819	194.02
194.03 07953	OTHER NONREIMBURSABLE COST CENTERS	230,590	0	0	230,590	194.03

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151303

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

Worksheet B
Part I
Date/Time Prepared:
11/26/2012 11:29 am

Cost Center Description		Net Expenses for Cost Allocation (from wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	4.00	4A	
194.04	07955 SPN	0	149,225	0	0	149,225	194.04
200.00	Cross Foot Adjustments					0	200.00
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	16,452,238	750,309	0	1,978,049	16,452,238	202.00

Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING		
		5.00	6.00	7.00	8.00	9.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS					4.00	
5.00	00500	ADMINISTRATIVE & GENERAL	4,332,466				5.00	
6.00	00600	MAINTENANCE & REPAIRS	0	0			6.00	
7.00	00700	OPERATION OF PLANT	314,885	0	1,195,753		7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	34,328	0	1,583	131,941	8.00	
9.00	00900	HOUSEKEEPING	159,787	0	29,916	40,330	677,027	9.00
10.00	01000	DIETARY	12,608	0	14,750	3,920	18,382	10.00
11.00	01100	CAFETERIA	82,883	0	30,395	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	99,222	0	3,458	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	45,119	0	24,250	0	0	14.00
15.00	01500	PHARMACY	216,295	0	13,646	0	5,515	15.00
16.00	01601	MEDICAL RECORDS & LIBRARY	96,611	0	115,436	0	6,434	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0	18.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	542,992	0	136,748	15,242	135,663	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	297,584	0	108,665	39,059	29,412	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
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	728,807	0	88,061	10,775	44,669	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
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	416,170	0	32,583	0	34,008	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	5,512	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	86,364	0	35,249	6,578	14,890	66.00
67.00	06700	OCCUPATIONAL THERAPY	12,938	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,213	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	8,706	0	4,146	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	118,334	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	81,008	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	701,505	0	87,957	12,724	108,089	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	0	93.00
SPECIAL PURPOSE COST CENTERS								
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,062,871	0	726,843	128,628	397,062	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	1,388	0	7,542	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,032	0	16,479	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	96,222	0	0	0	14,706	194.00
194.01	07951	TOBACCO / CHILD GRANT	0	0	0	0	0	194.01
194.02	07952	OUTPATIENT CLINICS	33,180	0	154,998	3,313	34,191	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	82,429	0	0	0	0	194.03
194.04	07955	SPN	53,344	0	289,891	0	231,068	194.04
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	4,332,466	0	1,195,753	131,941	677,027	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151303

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

Worksheet B
Part I
Date/Time Prepared:
11/26/2012 11:29 am

Cost Center Description		DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
		10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	84,930					10.00
11.00	01100	0	345,136				11.00
12.00	01200	0	0	0			12.00
13.00	01300	0	9,281	0	389,527		13.00
14.00	01400	0	8,718	0	0	204,303	14.00
15.00	01500	0	10,444	0	0	85	15.00
16.00	01601	0	16,187	0	0	22	16.00
17.00	01700	0	0	0	0	0	17.00
18.00	01850	0	0	0	0	0	18.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	84,930	91,618	0	205,387	17,728	30.00
31.00	03100	0	0	0	0	0	31.00
33.00	03300	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	38,780	0	49,576	4,928	50.00
51.00	05100	0	0	0	0	0	51.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	0	67,830	0	42,494	19,502	54.00
55.00	05500	0	0	0	0	0	55.00
56.00	05600	0	0	0	0	0	56.00
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	0	0	0	28,329	136	60.00
60.01	06001	0	0	0	0	0	60.01
61.00	06100	0	0	0	0	0	61.00
62.00	06200	0	0	0	0	0	62.00
63.00	06300	0	0	0	0	0	63.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	0	0	0	0	2,032	65.00
66.00	06600	0	0	0	0	1,959	66.00
67.00	06700	0	0	0	0	9	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	0	0	0	0	0	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	105,570	71.00
72.00	07200	0	0	0	0	6,200	72.00
73.00	07300	0	0	0	0	0	73.00
74.00	07400	0	0	0	0	0	74.00
75.00	07500	0	0	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0	0	88.00
91.00	09100	0	80,217	0	63,741	45,857	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	04040	0	0	0	0	0	93.00
SPECIAL PURPOSE COST CENTERS							
115.00	11500	0	0	0	0	0	115.00
116.00	11600	0	0	0	0	0	116.00
118.00		84,930	323,075	0	389,527	204,028	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	0	0	0	0	0	192.00
193.00	19300	0	0	0	0	0	193.00
194.00	07950	0	20,354	0	0	81	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	1,707	0	0	194	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07955	0	0	0	0	0	194.04
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		84,930	345,136	0	389,527	204,303	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151303

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

Worksheet B
Part I
Date/Time Prepared:
11/26/2012 11:29 am

Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE (SPECIFY)	Subtotal	
	15.00	16.00	17.00	18.00	24.00	
GENERAL SERVICE COST CENTERS						
1.00 00100						1.00
2.00 00200						2.00
4.00 00400						4.00
5.00 00500						5.00
6.00 00600						6.00
7.00 00700						7.00
8.00 00800						8.00
9.00 00900						9.00
10.00 01000						10.00
11.00 01100						11.00
12.00 01200						12.00
13.00 01300						13.00
14.00 01400						14.00
15.00 01500	851,056					15.00
16.00 01601	0	504,953				16.00
17.00 01700	0	0	0			17.00
18.00 01850	0	0	0	0		18.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	0	20,979	0	0	2,770,270	30.00
31.00 03100	0	0	0	0	0	31.00
33.00 03300	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	0	60,158	0	0	1,460,631	50.00
51.00 05100	0	0	0	0	0	51.00
52.00 05200	0	0	0	0	0	52.00
53.00 05300	0	0	0	0	0	53.00
54.00 05400	0	152,513	0	0	3,193,446	54.00
55.00 05500	0	0	0	0	0	55.00
56.00 05600	0	0	0	0	0	56.00
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	0	95,688	0	0	1,771,121	60.00
60.01 06001	0	0	0	0	0	60.01
61.00 06100	0	0	0	0	0	61.00
62.00 06200	0	0	0	0	0	62.00
63.00 06300	0	0	0	0	0	63.00
64.00 06400	0	0	0	0	0	64.00
65.00 06500	0	2,531	0	0	25,495	65.00
66.00 06600	0	12,240	0	0	398,877	66.00
67.00 06700	0	1,995	0	0	51,134	67.00
68.00 06800	0	123	0	0	4,729	68.00
69.00 06900	0	4,750	0	0	41,956	69.00
70.00 07000	0	0	0	0	0	70.00
71.00 07100	0	13,081	0	0	568,015	71.00
72.00 07200	0	5,778	0	0	319,599	72.00
73.00 07300	851,056	26,432	0	0	877,488	73.00
74.00 07400	0	0	0	0	0	74.00
75.00 07500	0	0	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	0	21	0	0	21	88.00
91.00 09100	0	108,664	0	0	3,171,164	91.00
92.00 09200	0	0	0	0	0	92.00
93.00 04040	0	0	0	0	0	93.00
SPECIAL PURPOSE COST CENTERS						
115.00 11500	0	0	0	0	0	115.00
116.00 11600	0	0	0	0	0	116.00
118.00	851,056	504,953	0	0	14,653,946	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	0	0	0	0	12,812	190.00
191.00 19100	0	0	0	0	0	191.00
192.00 19200	0	0	0	0	27,994	192.00
193.00 19300	0	0	0	0	0	193.00
194.00 07950	0	0	0	0	400,537	194.00
194.01 07951	0	0	0	0	0	194.01
194.02 07952	0	0	0	0	320,402	194.02
194.03 07953	0	0	0	0	313,019	194.03
194.04 07955	0	0	0	0	723,528	194.04
200.00						200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151303

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

Worksheet B
Part I
Date/Time Prepared:
11/26/2012 11:29 am

Cost Center Description		PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE (SPECIFY)	Subtotal	
201.00	Negative Cost Centers	15.00	16.00	17.00	18.00	24.00	0
202.00	TOTAL (sum lines 118-201)	851,056	504,953	0	0	16,452,238	201.00

Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
6.00	00600	MAINTENANCE & REPAIRS		6.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
12.00	01200	MAINTENANCE OF PERSONNEL		12.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01601	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE		17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)		18.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	2,770,270
31.00	03100	INTENSIVE CARE UNIT	0	0
33.00	03300	BURN INTENSIVE CARE UNIT	0	0
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	1,460,631
51.00	05100	RECOVERY ROOM	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0
53.00	05300	ANESTHESIOLOGY	0	0
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	3,193,446
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0
56.00	05600	RADIOISOTOPE	0	0
57.00	05700	CT SCAN	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0
60.00	06000	LABORATORY	0	1,771,121
60.01	06001	BLOOD LABORATORY	0	0
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0
64.00	06400	INTRAVENOUS THERAPY	0	0
65.00	06500	RESPIRATORY THERAPY	0	25,495
66.00	06600	PHYSICAL THERAPY	0	398,877
67.00	06700	OCCUPATIONAL THERAPY	0	51,134
68.00	06800	SPEECH PATHOLOGY	0	4,729
69.00	06900	ELECTROCARDIOLOGY	0	41,956
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	568,015
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	319,599
73.00	07300	DRUGS CHARGED TO PATIENTS	0	877,488
74.00	07400	RENAL DIALYSIS	0	0
75.00	07500	ASC (NON-DISTINCT PART)	0	0
OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	21
91.00	09100	EMERGENCY	0	3,171,164
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0
93.00	04040	FAMILY PRACTICE	0	0
SPECIAL PURPOSE COST CENTERS				
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0
116.00	11600	HOSPICE	0	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	14,653,946
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	12,812
191.00	19100	RESEARCH	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	27,994
193.00	19300	NONPAID WORKERS	0	0
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	400,537
194.01	07951	TOBACCO / CHILD GRANT	0	0
194.02	07952	OUTPATIENT CLINICS	0	320,402
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	313,019
194.04	07955	SPN	0	723,528
200.00		Cross Foot Adjustments	0	0

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151303

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

Worksheet B
Part I
Date/Time Prepared:
11/26/2012 11:29 am

Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
201.00	Negative Cost Centers	25.00	26.00	
202.00	TOTAL (sum lines 118-201)	0	16,452,238	201.00 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151303

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

Worksheet B
Part II
Date/Time Prepared:
11/26/2012 11:29 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS	3,414	0	3,414	3,414	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	6,457	66,285	72,742	890	5.00
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00 00700	OPERATION OF PLANT	3,334	68,495	71,829	79	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	815	815	0	8.00
9.00 00900	HOUSEKEEPING	707	15,400	16,107	93	9.00
10.00 01000	DIETARY	860	7,593	8,453	24	10.00
11.00 01100	CAFETERIA	0	15,646	15,646	65	11.00
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00 01300	NURSING ADMINISTRATION	257	1,780	2,037	105	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	12,483	12,483	38	14.00
15.00 01500	PHARMACY	1,774	7,024	8,798	88	15.00
16.00 01601	MEDICAL RECORDS & LIBRARY	0	59,422	59,422	70	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	17.00
18.00 01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	18.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	15,101	70,393	85,494	537	30.00
31.00 03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
33.00 03300	BURN INTENSIVE CARE UNIT	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	35,468	55,937	91,405	220	50.00
51.00 05100	RECOVERY ROOM	0	0	0	0	51.00
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	32,600	45,331	77,931	460	54.00
55.00 05500	RADIOLOGY - THERAPEUTIC	0	0	0	0	55.00
56.00 05600	RADIOISOTOPE	0	0	0	0	56.00
57.00 05700	CT SCAN	0	0	0	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00 06000	LABORATORY	49	16,772	16,821	0	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	60.01
61.00 06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0	0	0	61.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	62.00
63.00 06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	63.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00 06600	PHYSICAL THERAPY	1,490	18,145	19,635	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	2,134	2,134	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00 07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	74.00
75.00 07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
91.00 09100	EMERGENCY	4,848	45,277	50,125	658	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
93.00 04040	FAMILY PRACTICE	0	0	0	0	93.00
SPECIAL PURPOSE COST CENTERS						
115.00 11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	115.00
116.00 11600	HOSPICE	0	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	106,359	508,932	615,291	3,327	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	3,882	3,882	0	190.00
191.00 19100	RESEARCH	0	0	0	0	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	8,483	8,483	0	192.00
193.00 19300	NONPAID WORKERS	0	0	0	0	193.00
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	82	194.00
194.01 07951	TOBACCO / CHILD GRANT	0	0	0	0	194.01
194.02 07952	OUTPATIENT CLINICS	106	79,787	79,893	5	194.02
194.03 07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.03
194.04 07955	SPN	0	149,225	149,225	0	194.04

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151303

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

Worksheet B
Part II
Date/Time Prepared:
11/26/2012 11:29 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	2A	4.00	
200.00 Cross Foot Adjustments				0		200.00
201.00 Negative Cost Centers		0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	106,465	750,309	0	856,774	3,414	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151303

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

Worksheet B
Part II
Date/Time Prepared:
11/26/2012 11:29 am

Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500	73,632					5.00
6.00	00600	0	0				6.00
7.00	00700	5,351	0	77,259			7.00
8.00	00800	583	0	102	1,500		8.00
9.00	00900	2,715	0	1,933	457	21,305	9.00
10.00	01000	214	0	953	45	578	10.00
11.00	01100	1,409	0	1,964	0	0	11.00
12.00	01200	0	0	0	0	0	12.00
13.00	01300	1,686	0	223	0	0	13.00
14.00	01400	767	0	1,567	0	0	14.00
15.00	01500	3,676	0	882	0	174	15.00
16.00	01601	1,642	0	7,458	0	202	16.00
17.00	01700	0	0	0	0	0	17.00
18.00	01850	0	0	0	0	0	18.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	9,228	0	8,835	173	4,269	30.00
31.00	03100	0	0	0	0	0	31.00
33.00	03300	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	5,057	0	7,021	444	926	50.00
51.00	05100	0	0	0	0	0	51.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	12,387	0	5,690	123	1,406	54.00
55.00	05500	0	0	0	0	0	55.00
56.00	05600	0	0	0	0	0	56.00
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	7,073	0	2,105	0	1,070	60.00
60.01	06001	0	0	0	0	0	60.01
61.00	06100	0	0	0	0	0	61.00
62.00	06200	0	0	0	0	0	62.00
63.00	06300	0	0	0	0	0	63.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	94	0	0	0	0	65.00
66.00	06600	1,468	0	2,278	75	469	66.00
67.00	06700	220	0	0	0	0	67.00
68.00	06800	21	0	0	0	0	68.00
69.00	06900	148	0	268	0	0	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	2,011	0	0	0	0	71.00
72.00	07200	1,377	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
74.00	07400	0	0	0	0	0	74.00
75.00	07500	0	0	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0	0	88.00
91.00	09100	11,922	0	5,683	145	3,401	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	04040	0	0	0	0	0	93.00
SPECIAL PURPOSE COST CENTERS							
115.00	11500	0	0	0	0	0	115.00
116.00	11600	0	0	0	0	0	116.00
118.00		69,049	0	46,962	1,462	12,495	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	24	0	487	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	52	0	1,065	0	0	192.00
193.00	19300	0	0	0	0	0	193.00
194.00	07950	1,635	0	0	0	463	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	564	0	10,015	38	1,076	194.02
194.03	07953	1,401	0	0	0	0	194.03
194.04	07955	907	0	18,730	0	7,271	194.04
200.00							200.00
201.00							201.00
202.00		73,632	0	77,259	1,500	21,305	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151303

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

Worksheet B
Part II
Date/Time Prepared:
11/26/2012 11:29 am

Cost Center Description		DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
		10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	10,267					10.00
11.00	01100	0	19,084				11.00
12.00	01200	0	0	0			12.00
13.00	01300	0	513	0	4,564		13.00
14.00	01400	0	482	0	0	15,337	14.00
15.00	01500	0	578	0	0	6	15.00
16.00	01601	0	895	0	0	2	16.00
17.00	01700	0	0	0	0	0	17.00
18.00	01850	0	0	0	0	0	18.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	10,267	5,066	0	2,406	1,331	30.00
31.00	03100	0	0	0	0	0	31.00
33.00	03300	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	2,144	0	581	370	50.00
51.00	05100	0	0	0	0	0	51.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	0	3,751	0	498	1,464	54.00
55.00	05500	0	0	0	0	0	55.00
56.00	05600	0	0	0	0	0	56.00
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	0	0	0	332	10	60.00
60.01	06001	0	0	0	0	0	60.01
61.00	06100	0	0	0	0	0	61.00
62.00	06200	0	0	0	0	0	62.00
63.00	06300	0	0	0	0	0	63.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	0	0	0	0	153	65.00
66.00	06600	0	0	0	0	147	66.00
67.00	06700	0	0	0	0	1	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	0	0	0	0	0	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	7,924	71.00
72.00	07200	0	0	0	0	465	72.00
73.00	07300	0	0	0	0	0	73.00
74.00	07400	0	0	0	0	0	74.00
75.00	07500	0	0	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0	0	88.00
91.00	09100	0	4,436	0	747	3,443	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	04040	0	0	0	0	0	93.00
SPECIAL PURPOSE COST CENTERS							
115.00	11500	0	0	0	0	0	115.00
116.00	11600	0	0	0	0	0	116.00
118.00		10,267	17,865	0	4,564	15,316	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	0	0	0	0	0	192.00
193.00	19300	0	0	0	0	0	193.00
194.00	07950	0	1,125	0	0	6	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	94	0	0	15	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07955	0	0	0	0	0	194.04
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		10,267	19,084	0	4,564	15,337	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151303

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

Worksheet B
Part II
Date/Time Prepared:
11/26/2012 11:29 am

Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE (SPECIFY)	Subtotal	
	15.00	16.00	17.00	18.00	24.00	
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS						4.00
5.00 00500 ADMINISTRATIVE & GENERAL						5.00
6.00 00600 MAINTENANCE & REPAIRS						6.00
7.00 00700 OPERATION OF PLANT						7.00
8.00 00800 LAUNDRY & LINEN SERVICE						8.00
9.00 00900 HOUSEKEEPING						9.00
10.00 01000 DIETARY						10.00
11.00 01100 CAFETERIA						11.00
12.00 01200 MAINTENANCE OF PERSONNEL						12.00
13.00 01300 NURSING ADMINISTRATION						13.00
14.00 01400 CENTRAL SERVICES & SUPPLY						14.00
15.00 01500 PHARMACY	14,202					15.00
16.00 01601 MEDICAL RECORDS & LIBRARY	0	69,691				16.00
17.00 01700 SOCIAL SERVICE	0	0	0			17.00
18.00 01850 OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0		18.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	0	2,895	0	0	130,501	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0	0	0	0	31.00
33.00 03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	8,303	0	0	116,471	50.00
51.00 05100 RECOVERY ROOM	0	0	0	0	0	51.00
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	21,051	0	0	124,761	54.00
55.00 05500 RADIOLOGY - THERAPEUTIC	0	0	0	0	0	55.00
56.00 05600 RADIOISOTOPE	0	0	0	0	0	56.00
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	13,206	0	0	40,617	60.00
60.01 06001 BLOOD LABORATORY	0	0	0	0	0	60.01
61.00 06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0	0	0	0	61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	0	349	0	0	596	65.00
66.00 06600 PHYSICAL THERAPY	0	1,689	0	0	25,761	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	275	0	0	496	67.00
68.00 06800 SPEECH PATHOLOGY	0	17	0	0	38	68.00
69.00 06900 ELECTROCARDIOLOGY	0	656	0	0	3,206	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,805	0	0	11,740	71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	797	0	0	2,639	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	14,202	3,648	0	0	17,850	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	3	0	0	3	88.00
91.00 09100 EMERGENCY	0	14,997	0	0	95,557	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00 04040 FAMILY PRACTICE	0	0	0	0	0	93.00
SPECIAL PURPOSE COST CENTERS						
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00 11600 HOSPICE	0	0	0	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	14,202	69,691	0	0	570,236	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	4,393	190.00
191.00 19100 RESEARCH	0	0	0	0	0	191.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	9,600	192.00
193.00 19300 NONPAID WORKERS	0	0	0	0	0	193.00
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	3,311	194.00
194.01 07951 TOBACCO / CHILD GRANT	0	0	0	0	0	194.01
194.02 07952 OUTPATIENT CLINICS	0	0	0	0	91,700	194.02
194.03 07953 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	1,401	194.03
194.04 07955 SPN	0	0	0	0	176,133	194.04
200.00 Cross Foot Adjustments					0	200.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151303

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

Worksheet B
Part II
Date/Time Prepared:
11/26/2012 11:29 am

Cost Center Description		PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE (SPECIFY)	Subtotal	
		15.00	16.00	17.00	18.00	24.00	
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	14,202	69,691	0	0	856,774	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151303

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

Worksheet B
Part II
Date/Time Prepared:
11/26/2012 11:29 am

Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
6.00	00600	MAINTENANCE & REPAIRS		6.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
12.00	01200	MAINTENANCE OF PERSONNEL		12.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01601	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE		17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)		18.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	130,501	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	33.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	116,471	50.00
51.00	05100	RECOVERY ROOM	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	52.00
53.00	05300	ANESTHESIOLOGY	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	124,761	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	55.00
56.00	05600	RADIOISOTOPE	0	56.00
57.00	05700	CT SCAN	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	59.00
60.00	06000	LABORATORY	40,617	60.00
60.01	06001	BLOOD LABORATORY	0	60.01
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	62.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	64.00
65.00	06500	RESPIRATORY THERAPY	596	65.00
66.00	06600	PHYSICAL THERAPY	25,761	66.00
67.00	06700	OCCUPATIONAL THERAPY	496	67.00
68.00	06800	SPEECH PATHOLOGY	38	68.00
69.00	06900	ELECTROCARDIOLOGY	3,206	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	11,740	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	2,639	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	17,850	73.00
74.00	07400	RENAL DIALYSIS	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	75.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	3	88.00
91.00	09100	EMERGENCY	95,557	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	92.00
93.00	04040	FAMILY PRACTICE	0	93.00
SPECIAL PURPOSE COST CENTERS				
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	115.00
116.00	11600	HOSPICE	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	570,236	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	4,393	190.00
191.00	19100	RESEARCH	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	9,600	192.00
193.00	19300	NONPAID WORKERS	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	3,311	194.00
194.01	07951	TOBACCO / CHILD GRANT	0	194.01
194.02	07952	OUTPATIENT CLINICS	91,700	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	1,401	194.03
194.04	07955	SPN	176,133	194.04
200.00		Cross Foot Adjustments	0	200.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151303

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

Worksheet B
Part II
Date/Time Prepared:
11/26/2012 11:29 am

Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
201.00	Negative Cost Centers	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	856,774	202.00

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	69,965	0	0	0	1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	2.00
4.00 00400	EMPLOYEE BENEFITS	0	0	6,144,788	0	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	6,181	0	1,602,958	-4,332,466	5.00
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00 00700	OPERATION OF PLANT	6,387	0	142,849	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	76	0	0	0	8.00
9.00 00900	HOUSEKEEPING	1,436	0	167,788	0	9.00
10.00 01000	DIETARY	708	0	42,781	0	10.00
11.00 01100	CAFETERIA	1,459	0	117,089	0	11.00
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00 01300	NURSING ADMINISTRATION	166	0	189,138	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	1,164	0	68,094	0	14.00
15.00 01500	PHARMACY	655	0	158,314	0	15.00
16.00 01601	MEDICAL RECORDS & LIBRARY	5,541	0	125,339	0	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	17.00
18.00 01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	18.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	6,564	0	966,266	0	30.00
31.00 03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
33.00 03300	BURN INTENSIVE CARE UNIT	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	5,216	0	395,483	0	50.00
51.00 05100	RECOVERY ROOM	0	0	0	0	51.00
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	4,227	0	827,428	0	54.00
55.00 05500	RADIOLOGY - THERAPEUTIC	0	0	0	0	55.00
56.00 05600	RADIOISOTOPE	0	0	0	0	56.00
57.00 05700	CT SCAN	0	0	0	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00 06000	LABORATORY	1,564	0	0	0	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	60.01
61.00 06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0	0	0	61.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	62.00
63.00 06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	63.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00 06600	PHYSICAL THERAPY	1,692	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	199	0	0	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00 07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	74.00
75.00 07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
91.00 09100	EMERGENCY	4,222	0	1,184,023	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
93.00 04040	FAMILY PRACTICE	0	0	0	0	93.00
SPECIAL PURPOSE COST CENTERS						
115.00 11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	115.00
116.00 11600	HOSPICE	0	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	47,457	0	5,987,550	-4,332,466	11,365,599
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	362	0	0	0	190.00
191.00 19100	RESEARCH	0	0	0	0	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	791	0	0	0	192.00
193.00 19300	NONPAID WORKERS	0	0	0	0	193.00
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	147,985	0	194.00
194.01 07951	TOBACCO / CHILD GRANT	0	0	0	0	194.01
194.02 07952	OUTPATIENT CLINICS	7,440	0	9,253	0	194.02
194.03 07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.03
194.04 07955	SPN	13,915	0	0	0	194.04

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151303

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

Worksheet B-1

Date/Time Prepared:
11/26/2012 11:29 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
	1.00	2.00				
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)	750,309	0	1,978,049	4,332,466	202.00
203.00	Unit cost multiplier (wkst. B, Part I)	10.724062	0.000000	0.321907	0.357471	203.00
204.00	Cost to be allocated (per wkst. B, Part II)			3,414	73,632	204.00
205.00	Unit cost multiplier (wkst. B, Part II)			0.000556	0.006075	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151303

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

Worksheet B-1

Date/Time Prepared:
11/26/2012 11:29 am

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (ITEMIZED BILLS)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
		6.00	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						5.00
6.00	00600	0					6.00
7.00	00700		57,397				7.00
8.00	00800		76	95,215			8.00
9.00	00900	0	1,436	29,104	3,683		9.00
10.00	01000	0	708	2,829	100	100	10.00
11.00	01100	0	1,459	0	0	0	11.00
12.00	01200	0	0	0	0	0	12.00
13.00	01300	0	166	0	0	0	13.00
14.00	01400	0	1,164	0	0	0	14.00
15.00	01500	0	655	0	30	0	15.00
16.00	01601	0	5,541	0	35	0	16.00
17.00	01700	0	0	0	0	0	17.00
18.00	01850	0	0	0	0	0	18.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	0	6,564	10,999	738	100	30.00
31.00	03100	0	0	0	0	0	31.00
33.00	03300	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	5,216	28,187	160	0	50.00
51.00	05100	0	0	0	0	0	51.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	0	4,227	7,776	243	0	54.00
55.00	05500	0	0	0	0	0	55.00
56.00	05600	0	0	0	0	0	56.00
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	0	1,564	0	185	0	60.00
60.01	06001	0	0	0	0	0	60.01
61.00	06100	0	0	0	0	0	61.00
62.00	06200	0	0	0	0	0	62.00
63.00	06300	0	0	0	0	0	63.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	0	0	0	0	0	65.00
66.00	06600	0	1,692	4,747	81	0	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	0	199	0	0	0	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
74.00	07400	0	0	0	0	0	74.00
75.00	07500	0	0	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0	0	88.00
91.00	09100	0	4,222	9,182	588	0	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	04040	0	0	0	0	0	93.00
SPECIAL PURPOSE COST CENTERS							
115.00	11500	0	0	0	0	0	115.00
116.00	11600	0	0	0	0	0	116.00
118.00		0	34,889	92,824	2,160	100	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	362	0	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	0	791	0	0	0	192.00
193.00	19300	0	0	0	0	0	193.00
194.00	07950	0	0	0	80	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	7,440	2,391	186	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07955	0	13,915	0	1,257	0	194.04
200.00							200.00
201.00							201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151303

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

Worksheet B-1
Date/Time Prepared:
11/26/2012 11:29 am

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (ITEMIZED BILLS)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
202.00	Cost to be allocated (per wkst. B, Part I)	0	1,195,753	131,941	677,027	84,930	202.00
203.00	Unit cost multiplier (wkst. B, Part I)	0.000000	20.833023	1.385717	183.824871	849.300000	203.00
204.00	Cost to be allocated (per wkst. B, Part II)	0	77,259	1,500	21,305	10,267	204.00
205.00	Unit cost multiplier (wkst. B, Part II)	0.000000	1.346046	0.015754	5.784686	102.670000	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151303

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

Worksheet B-1

Date/Time Prepared:
11/26/2012 11:29 am

Cost Center Description		CAFETERIA (HOURS)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
		11.00	12.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	156,931					11.00
12.00	01200	0	0				12.00
13.00	01300	4,220	0	110			13.00
14.00	01400	3,964	0	0	337,115		14.00
15.00	01500	4,749	0	0	141	100	15.00
16.00	01601	7,360	0	0	37	0	16.00
17.00	01700	0	0	0	0	0	17.00
18.00	01850	0	0	0	0	0	18.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	41,658	0	58	29,252	0	30.00
31.00	03100	0	0	0	0	0	31.00
33.00	03300	0	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	17,633	0	14	8,131	0	50.00
51.00	05100	0	0	0	0	0	51.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	30,842	0	12	32,180	0	54.00
55.00	05500	0	0	0	0	0	55.00
56.00	05600	0	0	0	0	0	56.00
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	0	0	8	224	0	60.00
60.01	06001	0	0	0	0	0	60.01
61.00	06100	0	0	0	0	0	61.00
62.00	06200	0	0	0	0	0	62.00
63.00	06300	0	0	0	0	0	63.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	0	0	0	3,353	0	65.00
66.00	06600	0	0	0	3,232	0	66.00
67.00	06700	0	0	0	15	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	0	0	0	0	0	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	174,199	0	71.00
72.00	07200	0	0	0	10,230	0	72.00
73.00	07300	0	0	0	0	100	73.00
74.00	07400	0	0	0	0	0	74.00
75.00	07500	0	0	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0	0	88.00
91.00	09100	36,474	0	18	75,668	0	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	04040	0	0	0	0	0	93.00
SPECIAL PURPOSE COST CENTERS							
115.00	11500	0	0	0	0	0	115.00
116.00	11600	0	0	0	0	0	116.00
118.00		146,900	0	110	336,662	100	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	0	0	0	0	0	192.00
193.00	19300	0	0	0	0	0	193.00
194.00	07950	9,255	0	0	133	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	776	0	0	320	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07955	0	0	0	0	0	194.04
200.00							200.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151303

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

Worksheet B-1

Date/Time Prepared:
11/26/2012 11:29 am

Cost Center Description		CAFETERIA (HOURS)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
		11.00	12.00	13.00	14.00	15.00	
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per wkst. B, Part I)	345,136	0	389,527	204,303	851,056	202.00
203.00	Unit cost multiplier (wkst. B, Part I)	2.199285	0.000000	3,541.154545	0.606034	8,510.560000	203.00
204.00	Cost to be allocated (per wkst. B, Part II)	19,084	0	4,564	15,337	14,202	204.00
205.00	Unit cost multiplier (wkst. B, Part II)	0.121608	0.000000	41.490909	0.045495	142.020000	205.00

Cost Center Description		MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	OTHER GENERAL SERVICE (SPECIFY)	
		16.00	17.00	18.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
6.00	00600	MAINTENANCE & REPAIRS			6.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
12.00	01200	MAINTENANCE OF PERSONNEL			12.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01601	MEDICAL RECORDS & LIBRARY	47,150,865		16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	18.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	1,958,964	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	33.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	5,617,554	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	14,240,162	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	8,935,294	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	236,379	0	65.00
66.00	06600	PHYSICAL THERAPY	1,143,001	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	186,251	0	67.00
68.00	06800	SPEECH PATHOLOGY	11,528	0	68.00
69.00	06900	ELECTROCARDIOLOGY	443,511	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,221,540	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	539,574	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,468,173	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	75.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	1,992	0	88.00
91.00	09100	EMERGENCY	10,146,942	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	93.00
SPECIAL PURPOSE COST CENTERS					
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	115.00
116.00	11600	HOSPICE	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	47,150,865	0	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	190.00
191.00	19100	RESEARCH	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.00
194.01	07951	TOBACCO / CHILD GRANT	0	0	194.01
194.02	07952	OUTPATIENT CLINICS	0	0	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.03

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151303

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

Worksheet B-1
Date/Time Prepared:
11/26/2012 11:29 am

Cost Center Description		MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	OTHER GENERAL SERVICE (SPECIFY)	
		16.00	17.00	18.00	
194.04	07955 SPN	0	0	0	194.04
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)	504,953	0	0	202.00
203.00	Unit cost multiplier (wkst. B, Part I)	0.010709	0.000000	0.000000	203.00
204.00	Cost to be allocated (per wkst. B, Part II)	69,691	0	0	204.00
205.00	Unit cost multiplier (wkst. B, Part II)	0.001478	0.000000	0.000000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151303

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

Worksheet C
Part I
Date/Time Prepared:
11/26/2012 11:29 am

		Title XVIII		Hospital		Cost	
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Disallowance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,770,270		2,770,270	0	0
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0
33.00	03300	BURN INTENSIVE CARE UNIT	0		0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,460,631		1,460,631	0	0
51.00	05100	RECOVERY ROOM	0		0	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0
53.00	05300	ANESTHESIOLOGY	0		0	0	0
54.00	05400	RADIOLOGY - DIAGNOSTIC	3,193,446		3,193,446	0	0
55.00	05500	RADIOLOGY - THERAPEUTIC	0		0	0	0
56.00	05600	RADIOISOTOPE	0		0	0	0
57.00	05700	CT SCAN	0		0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0
60.00	06000	LABORATORY	1,771,121		1,771,121	0	0
60.01	06001	BLOOD LABORATORY	0		0	0	0
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0		0	0	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0		0	0	0
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0		0	0	0
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0
65.00	06500	RESPIRATORY THERAPY	25,495	0	25,495	0	0
66.00	06600	PHYSICAL THERAPY	398,877	0	398,877	0	0
67.00	06700	OCCUPATIONAL THERAPY	51,134	0	51,134	0	0
68.00	06800	SPEECH PATHOLOGY	4,729	0	4,729	0	0
69.00	06900	ELECTROCARDIOLOGY	41,956		41,956	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	568,015		568,015	0	0
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	319,599		319,599	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	877,488		877,488	0	0
74.00	07400	RENAL DIALYSIS	0		0	0	0
75.00	07500	ASC (NON-DISTINCT PART)	0		0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	21		21	0	0
91.00	09100	EMERGENCY	3,171,164		3,171,164	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	607,877		607,877	0	0
93.00	04040	FAMILY PRACTICE	0		0	0	0
SPECIAL PURPOSE COST CENTERS							
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0		0	0	0
116.00	11600	HOSPICE	0		0	0	0
200.00		Subtotal (see instructions)	15,261,823	0	15,261,823	0	0
201.00		Less Observation Beds	607,877		607,877	0	0
202.00		Total (see instructions)	14,653,946	0	14,653,946	0	0

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151303

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

Worksheet C
Part I
Date/Time Prepared:
11/26/2012 11:29 am

Cost Center Description	Title XVIII			Hospital	Cost			
	Charges		Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio			
	Inpatient	Outpatient						
	6.00	7.00	8.00	9.00	10.00			
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,638,293		1,638,293		30.00	
31.00	03100	INTENSIVE CARE UNIT	0		0		31.00	
33.00	03300	BURN INTENSIVE CARE UNIT	0		0		33.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	54,579	5,562,975	5,617,554	0.260012	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	438,731	13,801,431	14,240,162	0.224256	0.000000	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0.000000	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	463,304	8,471,990	8,935,294	0.198216	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0	0	0.000000	0.000000	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0.000000	0.000000	62.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0.000000	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	225,232	11,147	236,379	0.107856	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	181,742	961,259	1,143,001	0.348973	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	89,860	96,391	186,251	0.274543	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	2,878	8,650	11,528	0.410219	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	55,257	388,254	443,511	0.094600	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	259,396	962,144	1,221,540	0.464999	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	539,574	539,574	0.592317	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	886,810	1,581,363	2,468,173	0.355521	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	75.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	1,992	1,992			88.00
91.00	09100	EMERGENCY	174,254	9,972,688	10,146,942	0.312524	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	320,671	320,671	1.895641	0.000000	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0.000000	0.000000	93.00
SPECIAL PURPOSE COST CENTERS								
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0			115.00
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	4,470,336	42,680,529	47,150,865			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	4,470,336	42,680,529	47,150,865			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151303

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

Worksheet C
Part I
Date/Time Prepared:
11/26/2012 11:29 am

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
33.00	03300	BURN INTENSIVE CARE UNIT			33.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
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
55.00	05500	RADIOLOGY - THERAPEUTIC	0.000000		55.00
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.000000		60.00
60.01	06001	BLOOD LABORATORY-	0.000000		60.01
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0.000000		61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000		62.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.000000		63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
74.00	07400	RENAL DIALYSIS	0.000000		74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000		75.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC			88.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
93.00	04040	FAMILY PRACTICE	0.000000		93.00
SPECIAL PURPOSE COST CENTERS					
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)			115.00
116.00	11600	HOSPICE			116.00
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: 151303

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

Worksheet C
Part I
Date/Time Prepared:
11/26/2012 11:29 am

		Title XIX		Hospital		PPS		
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Disallowance	Total Costs		
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,770,270		2,770,270	0	2,770,270	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	0		0	0	0	33.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,460,631		1,460,631	0	1,460,631	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
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	3,193,446		3,193,446	0	3,193,446	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0		0	0	0	55.00
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	1,771,121		1,771,121	0	1,771,121	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0		0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0		0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0		0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	25,495	0	25,495	0	25,495	65.00
66.00	06600	PHYSICAL THERAPY	398,877	0	398,877	0	398,877	66.00
67.00	06700	OCCUPATIONAL THERAPY	51,134	0	51,134	0	51,134	67.00
68.00	06800	SPEECH PATHOLOGY	4,729	0	4,729	0	4,729	68.00
69.00	06900	ELECTROCARDIOLOGY	41,956	0	41,956	0	41,956	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	568,015		568,015	0	568,015	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	319,599		319,599	0	319,599	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	877,488		877,488	0	877,488	73.00
74.00	07400	RENAL DIALYSIS	0		0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0		0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	21		21	0	21	88.00
91.00	09100	EMERGENCY	3,171,164		3,171,164	0	3,171,164	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	607,877		607,877	0	607,877	92.00
93.00	04040	FAMILY PRACTICE	0		0	0	0	93.00
SPECIAL PURPOSE COST CENTERS								
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0		0	0	0	115.00
116.00	11600	HOSPICE	0		0	0	0	116.00
200.00		Subtotal (see instructions)	15,261,823	0	15,261,823	0	15,261,823	200.00
201.00		Less Observation Beds	607,877		607,877	0	607,877	201.00
202.00		Total (see instructions)	14,653,946	0	14,653,946	0	14,653,946	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151303

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

Worksheet C
Part I
Date/Time Prepared:
11/26/2012 11:29 am

Cost Center Description		Title XIX			Hospital	PPS		
		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
		Inpatient	Outpatient	Total (col. 6 + col. 7)				
6.00	7.00	8.00	9.00	10.00				
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,638,293		1,638,293			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
33.00	03300	BURN INTENSIVE CARE UNIT	0		0			33.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	54,579	5,562,975	5,617,554	0.260012	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	438,731	13,801,431	14,240,162	0.224256	0.000000	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0.000000	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	463,304	8,471,990	8,935,294	0.198216	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0	0	0.000000	0.000000	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0.000000	0.000000	62.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0.000000	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	225,232	11,147	236,379	0.107856	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	181,742	961,259	1,143,001	0.348973	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	89,860	96,391	186,251	0.274543	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	2,878	8,650	11,528	0.410219	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	55,257	388,254	443,511	0.094600	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	259,396	962,144	1,221,540	0.464999	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	539,574	539,574	0.592317	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	886,810	1,581,363	2,468,173	0.355521	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	75.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	1,992	1,992	0.010542	0.000000	88.00
91.00	09100	EMERGENCY	174,254	9,972,688	10,146,942	0.312524	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	320,671	320,671	1.895641	0.000000	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0.000000	0.000000	93.00
SPECIAL PURPOSE COST CENTERS								
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0			115.00
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	4,470,336	42,680,529	47,150,865			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	4,470,336	42,680,529	47,150,865			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151303

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

Worksheet C
Part I
Date/Time Prepared:
11/26/2012 11:29 am

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	PPS
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
33.00	03300	BURN INTENSIVE CARE UNIT			33.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.260012		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.224256		54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.000000		55.00
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.198216		60.00
60.01	06001	BLOOD LABORATORY	0.000000		60.01
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0.000000		61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000		62.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.000000		63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.107856		65.00
66.00	06600	PHYSICAL THERAPY	0.348973		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.274543		67.00
68.00	06800	SPEECH PATHOLOGY	0.410219		68.00
69.00	06900	ELECTROCARDIOLOGY	0.094600		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.464999		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.592317		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.355521		73.00
74.00	07400	RENAL DIALYSIS	0.000000		74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000		75.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.010542		88.00
91.00	09100	EMERGENCY	0.312524		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.895641		92.00
93.00	04040	FAMILY PRACTICE	0.000000		93.00
SPECIAL PURPOSE COST CENTERS					
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)			115.00
116.00	11600	HOSPICE			116.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 151303

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

Worksheet C Part II Date/Time Prepared: 11/26/2012 11:29 am

Cost Center Description		Title XIX			Hospital		PPS
		Total Cost (wkst. B, Part I, col. 26)	Capital Cost (wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,460,631	116,471	1,344,160	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
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	3,193,446	124,761	3,068,685	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	1,771,121	40,617	1,730,504	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	25,495	596	24,899	0	65.00
66.00	06600	PHYSICAL THERAPY	398,877	25,761	373,116	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	51,134	496	50,638	0	67.00
68.00	06800	SPEECH PATHOLOGY	4,729	38	4,691	0	68.00
69.00	06900	ELECTROCARDIOLOGY	41,956	3,206	38,750	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	568,015	11,740	556,275	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	319,599	2,639	316,960	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	877,488	17,850	859,638	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	21	3	18	0	88.00
91.00	09100	EMERGENCY	3,171,164	95,557	3,075,607	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	607,877	0	607,877	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	93.00
SPECIAL PURPOSE COST CENTERS							
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	115.00
116.00	11600	HOSPICE	0	0	0	0	116.00
200.00		Subtotal (sum of lines 50 thru 199)	12,491,553	439,735	12,051,818	0	200.00
201.00		Less Observation Beds	607,877	0	607,877	0	201.00
202.00		Total (line 200 minus line 201)	11,883,676	439,735	11,443,941	0	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 151303

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

Worksheet C Part II Date/Time Prepared: 11/26/2012 11:29 am

Cost Center Description		Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	Hospital	PPS
		6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	1,460,631	5,617,554	0.260012		50.00
51.00	05100 RECOVERY ROOM	0	0	0.000000		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0.000000		52.00
53.00	05300 ANESTHESIOLOGY	0	0	0.000000		53.00
54.00	05400 RADIOLOGY - DIAGNOSTIC	3,193,446	14,240,162	0.224256		54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	0	0	0.000000		55.00
56.00	05600 RADIOISOTOPE	0	0	0.000000		56.00
57.00	05700 CT SCAN	0	0	0.000000		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000		58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000		59.00
60.00	06000 LABORATORY	1,771,121	8,935,294	0.198216		60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000		60.01
61.00	06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0	0.000000		61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.000000		62.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0	0	0.000000		63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0.000000		64.00
65.00	06500 RESPIRATORY THERAPY	25,495	236,379	0.107856		65.00
66.00	06600 PHYSICAL THERAPY	398,877	1,143,001	0.348973		66.00
67.00	06700 OCCUPATIONAL THERAPY	51,134	186,251	0.274543		67.00
68.00	06800 SPEECH PATHOLOGY	4,729	11,528	0.410219		68.00
69.00	06900 ELECTROCARDIOLOGY	41,956	443,511	0.094600		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0.000000		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	568,015	1,221,540	0.464999		71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	319,599	539,574	0.592317		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	877,488	2,468,173	0.355521		73.00
74.00	07400 RENAL DIALYSIS	0	0	0.000000		74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0.000000		75.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	21	1,992	0.010542		88.00
91.00	09100 EMERGENCY	3,171,164	10,146,942	0.312524		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	607,877	320,671	1.895641		92.00
93.00	04040 FAMILY PRACTICE	0	0	0.000000		93.00
SPECIAL PURPOSE COST CENTERS						
115.00	11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0	0.000000		115.00
116.00	11600 HOSPICE	0	0	0.000000		116.00
200.00	Subtotal (sum of lines 50 thru 199)	12,491,553	45,512,572			200.00
201.00	Less Observation Beds	607,877	0			201.00
202.00	Total (line 200 minus line 201)	11,883,676	45,512,572			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 151303	Period: From 07/01/2011 To 06/30/2012	Worksheet D Part II Date/Time Prepared: 11/26/2012 11:29 am
--	----------------------	---	--

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	116,471	5,617,554	0.020733	27,617	573	50.00
51.00 05100 RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00 05400 RADIOLOGY - DIAGNOSTIC	124,761	14,240,162	0.008761	137,923	1,208	54.00
55.00 05500 RADIOLOGY - THERAPEUTIC	0	0	0.000000	0	0	55.00
56.00 05600 RADIOISOTOPE	0	0	0.000000	0	0	56.00
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	40,617	8,935,294	0.004546	223,551	1,016	60.00
60.01 06001 BLOOD LABORATORY	0	0	0.000000	0	0	60.01
61.00 06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0	0.000000	0	0	61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.000000	0	0	62.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0	0	0.000000	0	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	596	236,379	0.002521	94,546	238	65.00
66.00 06600 PHYSICAL THERAPY	25,761	1,143,001	0.022538	34,011	767	66.00
67.00 06700 OCCUPATIONAL THERAPY	496	186,251	0.002663	16,059	43	67.00
68.00 06800 SPEECH PATHOLOGY	38	11,528	0.003296	507	2	68.00
69.00 06900 ELECTROCARDIOLOGY	3,206	443,511	0.007229	51,485	372	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	11,740	1,221,540	0.009611	116,495	1,120	71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	2,639	539,574	0.004891	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	17,850	2,468,173	0.007232	363,643	2,630	73.00
74.00 07400 RENAL DIALYSIS	0	0	0.000000	0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	3	1,992	0.001506	0	0	88.00
91.00 09100 EMERGENCY	95,557	10,146,942	0.009417	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	320,671	0.000000	0	0	92.00
93.00 04040 FAMILY PRACTICE	0	0	0.000000	0	0	93.00
200.00 Total (lines 50-199)	439,735	45,512,572		1,065,837	7,969	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151303

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

Worksheet D
Part IV
Date/Time Prepared:
11/26/2012 11:29 am

Cost Center Description	Title XVIII				Hospital	Total Cost (sum of col 1 through col. 4)	
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost			
	1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
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
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	93.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151303

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

Worksheet D Part IV Date/Time Prepared: 11/26/2012 11:29 am

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	5,617,554	0.000000	0.000000	27,617	50.00
51.00 05100 RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	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	14,240,162	0.000000	0.000000	137,923	54.00
55.00 05500 RADIOLOGY - THERAPEUTIC	0	0	0.000000	0.000000	0	55.00
56.00 05600 RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
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	8,935,294	0.000000	0.000000	223,551	60.00
60.01 06001 BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
61.00 06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0	0.000000	0.000000	0	61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.000000	0.000000	0	62.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0	0	0.000000	0.000000	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0	64.00
65.00 06500 RESPIRATORY THERAPY	0	236,379	0.000000	0.000000	94,546	65.00
66.00 06600 PHYSICAL THERAPY	0	1,143,001	0.000000	0.000000	34,011	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	186,251	0.000000	0.000000	16,059	67.00
68.00 06800 SPEECH PATHOLOGY	0	11,528	0.000000	0.000000	507	68.00
69.00 06900 ELECTROCARDIOLOGY	0	443,511	0.000000	0.000000	51,485	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,221,540	0.000000	0.000000	116,495	71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	539,574	0.000000	0.000000	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	2,468,173	0.000000	0.000000	363,643	73.00
74.00 07400 RENAL DIALYSIS	0	0	0.000000	0.000000	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0.000000	0.000000	0	75.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	1,992	0.000000	0.000000	0	88.00
91.00 09100 EMERGENCY	0	10,146,942	0.000000	0.000000	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	320,671	0.000000	0.000000	0	92.00
93.00 04040 FAMILY PRACTICE	0	0	0.000000	0.000000	0	93.00
200.00 Total (lines 50-199)	0	45,512,572			1,065,837	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151303

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

Worksheet D
Part IV
Date/Time Prepared:
11/26/2012 11:29 am

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
51.00 05100 RECOVERY ROOM	0	0	0	0	0	51.00
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
55.00 05500 RADIOLOGY - THERAPEUTIC	0	0	0	0	0	55.00
56.00 05600 RADIOISOTOPE	0	0	0	0	0	56.00
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
60.01 06001 BLOOD LABORATORY	0	0	0	0	0	60.01
61.00 06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0	0	0	0	61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
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
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
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
93.00 04040 FAMILY PRACTICE	0	0	0	0	0	93.00
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: 151303

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

Worksheet D
Part IV
Date/Time Prepared:
11/26/2012 11:29 am

Cost Center Description		Title XVIII		Hospital	Cost
		PSA Adj. Allied Health	PSA Adj. All other Medical Education Cost		
		23.00	24.00		
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
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
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	75.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	93.00
200.00		Total (lines 50-199)	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 151303	Period: From 07/01/2011 To 06/30/2012	Worksheet D Part V Date/Time Prepared: 11/26/2012 11:29 am			
Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Cost		
			PPS Reimbursed Services (see instructions)	Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)		
		1.00	2.00	3.00	4.00		
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.260012	0	1,771,662	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.224256	0	3,160,182	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.000000	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	56.00
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	0.198216	0	2,983,406	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0.000000	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.000000	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.107856	0	7,974	0	65.00
66.00	06600	PHYSICAL THERAPY	0.348973	0	193,295	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.274543	0	32,530	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.410219	0	3,558	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.094600	0	388,254	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.464999	0	301,691	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.592317	0	267,221	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.355521	0	492,812	9,927	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	88.00
91.00	09100	EMERGENCY	0.312524	0	2,344,880	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.895641	0	132,371	0	92.00
93.00	04040	FAMILY PRACTICE	0.000000	0	0	0	93.00
200.00		Subtotal (see instructions)		0	12,079,836	9,927	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges		0	0	0	201.00
202.00		Net Charges (line 200 +/- line 201)		0	12,079,836	9,927	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151303	Period: From 07/01/2011 To 06/30/2012	Worksheet D Part V Date/Time Prepared: 11/26/2012 11:29 am
--	----------------------	---	---

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	460,653	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	51.00
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	708,690	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	56.00
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	591,359	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	860	0	65.00
66.00	06600	PHYSICAL THERAPY	0	67,455	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	8,931	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,460	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	36,729	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	140,286	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	158,280	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	175,205	3,529	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	88.00
91.00	09100	EMERGENCY	0	732,831	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	250,928	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	93.00
200.00		Subtotal (see instructions)	0	3,333,667	3,529	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0	0	0	201.00
202.00		Net Charges (Line 200 +/- line 201)	0	3,333,667	3,529	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151303 Component CCN: 15Z303	Period: From 07/01/2011 To 06/30/2012	Worksheet D Part V Date/Time Prepared: 11/26/2012 11:29 am
--	---	---	---

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Swing Beds - SNF	Cost	
		PPS Reimbursed Services (see instructions)	Cost Reimbursed Subject To Ded. & Coins. (see instructions)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)			
							1.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.260012	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.224256	0	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.000000	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	56.00
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	0.198216	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0.000000	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.000000	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.107856	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.348973	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.274543	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.410219	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.094600	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.464999	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.592317	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.355521	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000				88.00
91.00	09100	EMERGENCY	0.312524	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.895641	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0.000000	0	0	0	93.00
200.00		Subtotal (see instructions)		0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges		0	0	0	201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151303 Component CCN: 15Z303	Period: From 07/01/2011 To 06/30/2012	Worksheet D Part V Date/Time Prepared: 11/26/2012 11:29 am
--	---	---	---

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)		
	5.00	6.00	7.00		
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	51.00
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
55.00	05500 RADIOLOGY - THERAPEUTIC	0	0	0	55.00
56.00	05600 RADIOISOTOPE	0	0	0	56.00
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
60.01	06001 BLOOD LABORATORY	0	0	0	60.01
61.00	06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0	0	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	64.00
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
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0	0	0	88.00
91.00	09100 EMERGENCY	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
93.00	04040 FAMILY PRACTICE	0	0	0	93.00
200.00	Subtotal (see instructions)	0	0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0	0	0	201.00
202.00	Net Charges (Line 200 +/- line 201)	0	0	0	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 151303

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

Worksheet D
Part I
Date/Time Prepared:
11/26/2012 11:29 am

Cost Center Description		Capital Related Cost (from wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	PPS
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	130,501	33,504	96,997	1,297	74.79	30.00
31.00	03100 INTENSIVE CARE UNIT	0		0	0	0.00	31.00
33.00	03300 BURN INTENSIVE CARE UNIT	0		0	0	0.00	33.00
200.00	Total (lines 30-199)	130,501		96,997	1,297		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 151303

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

Worksheet D
Part I
Date/Time Prepared:
11/26/2012 11:29 am

Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS	142	10,620	30.00
31.00	03100 INTENSIVE CARE UNIT	0	0	31.00
33.00	03300 BURN INTENSIVE CARE UNIT	0	0	33.00
200.00	Total (lines 30-199)	142	10,620	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 151303

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

Worksheet D
Part II
Date/Time Prepared:
11/26/2012 11:29 am

Cost Center Description		Capital Related Cost (from wkst. B, Part II, col. 26)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	PPS
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	116,471	5,617,554	0.020733	4,232	88
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0
54.00	05400	RADIOLOGY - DIAGNOSTIC	124,761	14,240,162	0.008761	47,164	413
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0.000000	0	0
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0
57.00	05700	CT SCAN	0	0	0.000000	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0
60.00	06000	LABORATORY	40,617	8,935,294	0.004546	49,733	226
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0	0.000000	0	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.000000	0	0
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0.000000	0	0
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0
65.00	06500	RESPIRATORY THERAPY	596	236,379	0.002521	14,665	37
66.00	06600	PHYSICAL THERAPY	25,761	1,143,001	0.022538	1,116	25
67.00	06700	OCCUPATIONAL THERAPY	496	186,251	0.002663	0	0
68.00	06800	SPEECH PATHOLOGY	38	11,528	0.003296	0	0
69.00	06900	ELECTROCARDIOLOGY	3,206	443,511	0.007229	3,528	26
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	11,740	1,221,540	0.009611	0	0
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	2,639	539,574	0.004891	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	17,850	2,468,173	0.007232	68,719	497
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	3	1,992	0.001506	0	0
91.00	09100	EMERGENCY	95,557	10,146,942	0.009417	151,832	1,430
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	38,738	320,671	0.120803	0	0
93.00	04040	FAMILY PRACTICE	0	0	0.000000	0	0
200.00		Total (lines 50-199)	478,473	45,512,572		340,989	2,742

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 151303		Period: From 07/01/2011 To 06/30/2012		Worksheet D Part III Date/Time Prepared: 11/26/2012 11:29 am	
Cost Center Description		Title XIX			Hospital		PPS
		Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	33.00
200.00		Total (lines 30-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151303	Period: From 07/01/2011 To 06/30/2012	Worksheet D Part III Date/Time Prepared: 11/26/2012 11:29 am
---	----------------------	---	---

Cost Center Description	Title XIX			Hospital	PPS	
	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. Nursing School	
	6.00	7.00	8.00	9.00	11.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	1,297	0.00	142	0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0.00	0	0	0	31.00
33.00 03300 BURN INTENSIVE CARE UNIT	0	0.00	0	0	0	33.00
200.00 Total (lines 30-199)	1,297		142	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151303	Period: From 07/01/2011 To 06/30/2012	Worksheet D Part III Date/Time Prepared: 11/26/2012 11:29 am
---	----------------------	---	---

Cost Center Description	Title XIX		Hospital	PPS
	PSA Adj. Allied Health Cost	PSA Adj. All Other Medical Education Cost		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00 03000 ADULTS & PEDIATRICS	0	0		30.00
31.00 03100 INTENSIVE CARE UNIT	0	0		31.00
33.00 03300 BURN INTENSIVE CARE UNIT	0	0		33.00
200.00 Total (lines 30-199)	0	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151303	Period: From 07/01/2011 To 06/30/2012	Worksheet D Part IV Date/Time Prepared: 11/26/2012 11:29 am
--	----------------------	---------------------------------------	---

Cost Center Description	Title XIX			Hospital	PPS	Total Cost (sum of col 1 through col. 4)	
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All other Medical Education Cost			
	1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	0	0	0	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00 05400 RADIOLOGY - DIAGNOSTIC	0	0	0	0	0	0	54.00
55.00 05500 RADIOLOGY - THERAPEUTIC	0	0	0	0	0	0	55.00
56.00 05600 RADIOISOTOPE	0	0	0	0	0	0	56.00
57.00 05700 CT SCAN	0	0	0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	0	59.00
60.00 06000 LABORATORY	0	0	0	0	0	0	60.00
60.01 06001 BLOOD LABORATORY	0	0	0	0	0	0	60.01
61.00 06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0	0	0	0	0	61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	0	62.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS							
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	0	88.00
91.00 09100 EMERGENCY	0	0	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00
93.00 04040 FAMILY PRACTICE	0	0	0	0	0	0	93.00
200.00 Total (lines 50-199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151303	Period: From 07/01/2011 To 06/30/2012	Worksheet D Part IV Date/Time Prepared: 11/26/2012 11:29 am
--	----------------------	---------------------------------------	---

Cost Center Description	Title XIX			Hospital		PPS
	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
	6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	5,617,554	0.000000	0.000000	4,232	50.00
51.00 05100 RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	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	14,240,162	0.000000	0.000000	47,164	54.00
55.00 05500 RADIOLOGY - THERAPEUTIC	0	0	0.000000	0.000000	0	55.00
56.00 05600 RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
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	8,935,294	0.000000	0.000000	49,733	60.00
60.01 06001 BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
61.00 06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0	0.000000	0.000000	0	61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.000000	0.000000	0	62.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0	0	0.000000	0.000000	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0	64.00
65.00 06500 RESPIRATORY THERAPY	0	236,379	0.000000	0.000000	14,665	65.00
66.00 06600 PHYSICAL THERAPY	0	1,143,001	0.000000	0.000000	1,116	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	186,251	0.000000	0.000000	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	11,528	0.000000	0.000000	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	443,511	0.000000	0.000000	3,528	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,221,540	0.000000	0.000000	0	71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	539,574	0.000000	0.000000	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	2,468,173	0.000000	0.000000	68,719	73.00
74.00 07400 RENAL DIALYSIS	0	0	0.000000	0.000000	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0.000000	0.000000	0	75.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	1,992	0.000000	0.000000	0	88.00
91.00 09100 EMERGENCY	0	10,146,942	0.000000	0.000000	151,832	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	320,671	0.000000	0.000000	0	92.00
93.00 04040 FAMILY PRACTICE	0	0	0.000000	0.000000	0	93.00
200.00 Total (lines 50-199)	0	45,512,572			340,989	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151303	Period: From 07/01/2011 To 06/30/2012	Worksheet D Part IV Date/Time Prepared: 11/26/2012 11:29 am
--	----------------------	---------------------------------------	---

Cost Center Description	Title XIX			Hospital	PPS	
	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
	11.00	12.00	13.00	21.00	22.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	0	0	0	51.00
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
55.00 05500 RADIOLOGY - THERAPEUTIC	0	0	0	0	0	55.00
56.00 05600 RADIOISOTOPE	0	0	0	0	0	56.00
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
60.01 06001 BLOOD LABORATORY	0	0	0	0	0	60.01
61.00 06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0	0	0	0	61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
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
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
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
93.00 04040 FAMILY PRACTICE	0	0	0	0	0	93.00
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: 151303

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

Worksheet D
Part IV
Date/Time Prepared:
11/26/2012 11:29 am

Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	Title XIX	Hospital	PPS
		23.00	24.00			
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
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
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0		55.00
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0		61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		75.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
93.00	04040	FAMILY PRACTICE	0	0		93.00
200.00		Total (lines 50-199)	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151303

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

Worksheet D-1

Date/Time Prepared:
11/26/2012 11:29 am

Title XVIII		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)		1,844 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,297 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)		912 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0 5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		448 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		50 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)		586 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)		224 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)		224 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	152.53	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	152.53	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,770,270	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)	7,626	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)	7,474	25.00
26.00	Total swing-bed cost (see instructions)	722,443	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,047,827	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28.00	General inpatient routine service charges (excluding swing-bed charges)	1,902,316	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	1,902,316	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	1.076491	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)	2,085.87	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,047,827	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)	1,578.89	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	925,230	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)	925,230	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151303

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

Worksheet D-1

Date/Time Prepared:
11/26/2012 11:29 am

Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Hospital Program Days	Program Cost (col. 3 x col. 4)	Cost
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT	0	0	0.00	0	0	45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
48.00	Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					297,428	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,222,658	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)					353,671	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					353,671	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					707,342	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)					385	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,578.90	88.00
89.00	observation bed cost (line 87 x line 88) (see instructions)					607,877	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 151303	Period: From 07/01/2011 To 06/30/2012	Worksheet D-1 Date/Time Prepared: 11/26/2012 11:29 am
---	----------------------	---	---

Cost Center Description	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	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

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 151303	Period: From 07/01/2011 To 06/30/2012	Worksheet D-1 Date/Time Prepared: 11/26/2012 11:29 am
---	----------------------	---	---

Cost Center Description	Title XIX	Hospital	PPS	
			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		1,844	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,297	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)		912	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		448	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)		50	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		142	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
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)		2,770,270	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)		711,222	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,059,048	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		1,894,716	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		1,894,716	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		1.086732	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)		2,077.54	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		2,059,048	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)		1,587.55	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		225,432	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)		225,432	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151303

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

Worksheet D-1

Date/Time Prepared:
11/26/2012 11:29 am

Cost Center Description	Title XIX			Hospital	PPS	
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00 CORONARY CARE UNIT						44.00
45.00 BURN INTENSIVE CARE UNIT	0	0	0.00	0	0	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)					95,722	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					321,154	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)					10,620	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					2,742	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					13,362	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					307,792	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)					385	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,587.55	88.00
89.00 observation bed cost (line 87 x line 88) (see instructions)					611,207	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151303

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

Worksheet D-1

Date/Time Prepared:
11/26/2012 11:29 am

Cost Center Description	Cost	Title XIX		Hospital	PPS	
		Routine Cost (from line 27)	column 1 + column 2			
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	130,501	2,059,048	0.063379	611,207	38,738	90.00
91.00 Nursing School cost	0	2,059,048	0.000000	611,207	0	91.00
92.00 Allied health cost	0	2,059,048	0.000000	611,207	0	92.00
93.00 All other Medical Education	0	2,059,048	0.000000	611,207	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 151303	Period: From 07/01/2011 To 06/30/2012	Worksheet D-3 Date/Time Prepared: 11/26/2012 11:29 am
--	----------------------	---	---

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			577,782		30.00
31.00	03100	INTENSIVE CARE UNIT			0		31.00
33.00	03300	BURN INTENSIVE CARE UNIT			0		33.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.260012		27,617	7,181	50.00
51.00	05100	RECOVERY ROOM	0.000000		0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000		0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.224256		137,923	30,930	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.000000		0	0	55.00
56.00	05600	RADIOISOTOPE	0.000000		0	0	56.00
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	0.198216		223,551	44,311	60.00
60.01	06001	BLOOD LABORATORY	0.000000		0	0	60.01
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0.000000		0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000		0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.000000		0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.107856		94,546	10,197	65.00
66.00	06600	PHYSICAL THERAPY	0.348973		34,011	11,869	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.274543		16,059	4,409	67.00
68.00	06800	SPEECH PATHOLOGY	0.410219		507	208	68.00
69.00	06900	ELECTROCARDIOLOGY	0.094600		51,485	4,870	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.464999		116,495	54,170	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.592317		0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.355521		363,643	129,283	73.00
74.00	07400	RENAL DIALYSIS	0.000000		0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000		0	0	75.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000			0	88.00
91.00	09100	EMERGENCY	0.312524		0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.895641		0	0	92.00
93.00	04040	FAMILY PRACTICE	0.000000		0	0	93.00
200.00		Total (sum of lines 50-94 and 96-98)			1,065,837	297,428	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)			1,065,837		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151303 Component CCN: 15Z303	Period: From 07/01/2011 To 06/30/2012	Worksheet D-3 Date/Time Prepared: 11/26/2012 11:29 am	
Cost Center Description		Title XVIII	Swing Beds - SNF	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		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
33.00	03300	BURN INTENSIVE CARE UNIT		0	33.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.260012	2,854	742 50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0 52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0 53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.224256	23,333	5,233 54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.000000	0	0 55.00
56.00	05600	RADIOISOTOPE	0.000000	0	0 56.00
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	0.198216	46,236	9,165 60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0 60.01
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0.000000	0	0 61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0 62.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.000000	0	0 63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0 64.00
65.00	06500	RESPIRATORY THERAPY	0.107856	42,010	4,531 65.00
66.00	06600	PHYSICAL THERAPY	0.348973	116,139	40,529 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.274543	60,125	16,507 67.00
68.00	06800	SPEECH PATHOLOGY	0.410219	2,359	968 68.00
69.00	06900	ELECTROCARDIOLOGY	0.094600	204	19 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.464999	69,997	32,549 71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.592317	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.355521	155,304	55,214 73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0 74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0 75.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		0 88.00
91.00	09100	EMERGENCY	0.312524	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.895641	0	0 92.00
93.00	04040	FAMILY PRACTICE	0.000000	0	0 93.00
200.00		Total (sum of lines 50-94 and 96-98)		518,561	165,457 200.00
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)		518,561	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 151303	Period: From 07/01/2011 To 06/30/2012	Worksheet D-3 Date/Time Prepared: 11/26/2012 11:29 am
	Title XIX	Hospital	PPS

Cost Center Description		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		157,701		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
33.00	03300 BURN INTENSIVE CARE UNIT		0		33.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.260012	4,232	1,100	50.00
51.00	05100 RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400 RADIOLOGY - DIAGNOSTIC	0.224256	47,164	10,577	54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	0.000000	0	0	55.00
56.00	05600 RADIOISOTOPE	0.000000	0	0	56.00
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	0.198216	49,733	9,858	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	60.01
61.00	06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0.000000	0	0	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0.000000	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.107856	14,665	1,582	65.00
66.00	06600 PHYSICAL THERAPY	0.348973	1,116	389	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.274543	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.410219	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.094600	3,528	334	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.464999	0	0	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.592317	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.355521	68,719	24,431	73.00
74.00	07400 RENAL DIALYSIS	0.000000	0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.010542	0	0	88.00
91.00	09100 EMERGENCY	0.312524	151,832	47,451	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.895641	0	0	92.00
93.00	04040 FAMILY PRACTICE	0.000000	0	0	93.00
200.00	Total (sum of lines 50-94 and 96-98)		340,989	95,722	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)		340,989		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151303	Period: From 07/01/2011 To 06/30/2012	Worksheet E Part B Date/Time Prepared: 11/26/2012 11:29 am
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		3,337,196	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)		3,337,196	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 charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		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)		3,370,568	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)		34,275	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		1,800,485	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)		1,535,808	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)		1,535,808	30.00
31.00	Primary payer payments		62	31.00
32.00	Subtotal (line 30 minus line 31)		1,535,746	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)		264,832	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		264,832	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		264,832	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)		1,800,578	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)		1,800,578	40.00
41.00	Interim payments		2,431,598	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)		-631,020	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: 151303	Period: From 07/01/2011 To 06/30/2012	Worksheet E Part B Date/Time Prepared: 11/26/2012 11:29 am
	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: 151303		Period: From 07/01/2011 To 06/30/2012		Worksheet E-1 Part I Date/Time Prepared: 11/26/2012 11:29 am	
		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		1,168,883		2,454,211	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0	06/22/2012	147,788	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM	04/02/2012	142,761	04/02/2012	170,401	3.50	
3.51		06/22/2012	12,785		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)		-155,546		-22,613	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)		1,013,337		2,431,598	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		42,583		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		631,020	6.02	
7.00	Total Medicare program liability (see instructions)		1,055,920		1,800,578	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: 151303
Component CCN: 152303

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

Worksheet E-1
Part I
Date/Time Prepared:
11/26/2012 11:29 am

		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		898,728		0	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM	04/02/2012	86,148		0	3.50	
3.51		06/22/2012	4,348		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)		-90,496		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)		808,232		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		66,735		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		874,967		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: 151303

Period:

Worksheet E-2

Component CCN: 15Z303

From 07/01/2011

Date/Time Prepared:

To 06/30/2012

11/26/2012 11:29 am

		Swing Beds - SNF		
		Part A	Part B	
Title XVIII		1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)	714,415	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from wkst. D-3, column 3, line 200 for Part A, and sum of wkst. D, Part V, columns 5 and 7, line 202 for Part B) (For CAH, see instructions)	167,112	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	448	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)	881,527	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	881,527	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)	881,527	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	6,560	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)	874,967	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)	874,967	0	19.00
20.00	Interim payments	808,232	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)	66,735	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151303	Period: From 07/01/2011 To 06/30/2012	Worksheet E-3 Part V Date/Time Prepared: 11/26/2012 11:29 am
		Title XVIII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)				
1.00	Inpatient services			1,222,658 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)			1,222,658 4.00
5.00	Primary payer payments			0 5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			1,234,885 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)			1,234,885 19.00
20.00	Deductibles (exclude professional component)			190,765 20.00
21.00	Excess reasonable cost (from line 16)			0 21.00
22.00	Subtotal (line 19 minus line 20)			1,044,120 22.00
23.00	Coinsurance			2,023 23.00
24.00	Subtotal (line 22 minus line 23)			1,042,097 24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			13,823 25.00
26.00	Adjusted reimbursable bad debts (see instructions)			13,823 26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			13,823 27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)			1,055,920 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)			1,055,920 30.00
31.00	Interim payments			1,013,337 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)			42,583 33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2			0 34.00

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

Provider CCN: 151303

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

Worksheet G

Date/Time Prepared:
11/26/2012 11:29 am

		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	803,249	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	16,326,396	0	0	0	4.00
5.00	Other receivable	18,013	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-13,674,675	0	0	0	6.00
7.00	Inventory	207,180	0	0	0	7.00
8.00	Prepaid expenses	158,812	0	0	0	8.00
9.00	Other current assets	3,291,129	203,517	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	7,130,104	203,517	0	0	11.00
FIXED ASSETS						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	18,416,420	0	0	0	15.00
16.00	Accumulated depreciation	-8,836,664	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	9,579,756	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	7,879	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	881,308	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	889,187	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	17,599,047	203,517	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	550,316	0	0	0	37.00
38.00	Salaries, wages, and fees payable	625,377	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	201,816	0	0	0	43.00
44.00	Other current liabilities	1,469,833	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2,847,342	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	12,079,091	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	12,079,091	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	14,926,433	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	2,672,614	0	0	0	52.00
53.00	Specific purpose fund	0	203,517	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	2,672,614	203,517	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	17,599,047	203,517	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151303

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

Worksheet G-1

Date/Time Prepared:
11/26/2012 11:29 am

	General Fund		Special Purpose Fund		
	1.00	2.00	3.00	4.00	
	1.00		2,383,647		
2.00		532,300			2.00
3.00		2,915,947		193,259	3.00
4.00	0		0		4.00
5.00	281,342		0		5.00
6.00	42,566		28,935		6.00
7.00	0		19,059		7.00
8.00	0		63,852		8.00
9.00	0		0		9.00
10.00		323,908		111,846	10.00
11.00		3,239,855		305,105	11.00
12.00	312		0		12.00
13.00	547,982		0		13.00
14.00	18,947		0		14.00
15.00	0		59,022		15.00
16.00	0		42,566		16.00
17.00	0		0		17.00
18.00		567,241		101,588	18.00
19.00		2,672,614		203,517	19.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151303

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

Worksheet G-1

Date/Time Prepared:
11/26/2012 11:29 am

	Endowment Fund		Plant Fund			
	5.00	6.00	7.00	8.00		
1.00						1.00
2.00						2.00
3.00						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: 151303

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
11/26/2012 11:29 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	1,902,316		1,902,316	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)	1,902,316		1,902,316	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	0		0	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT	0		0	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)	1,902,316		1,902,316	17.00
18.00	Ancillary services	2,408,828	32,715,065	35,123,893	18.00
19.00	Outpatient services	713,163	10,798,309	11,511,472	19.00
20.00	RURAL HEALTH CLINIC	0	2,014	2,014	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.)	0	0	0	25.00
26.00	HOSPICE	0	0	0	26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to wkst. G-3, line 1)	5,024,307	43,515,388	48,539,695	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per wkst. A, column 3, line 200)		17,021,053		29.00
30.00	BAD DEBTS	1,918,294			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		1,918,294		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)		18,939,347		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 151303

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

Worksheet G-3

Date/Time Prepared:
11/26/2012 11:29 am

		1.00	
1.00	Total patient revenues (from wkst. G-2, Part I, column 3, line 28)	48,539,695	1.00
2.00	Less contractual allowances and discounts on patients' accounts	30,283,643	2.00
3.00	Net patient revenues (line 1 minus line 2)	18,256,052	3.00
4.00	Less total operating expenses (from wkst. G-2, Part II, line 43)	18,939,347	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-683,295	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	196,652	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	23,857	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	13,372	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	310	21.00
22.00	Rental of hospital space	377,694	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER (SPECIFY)	0	24.00
24.01	OTHER - MISC	39,651	24.01
24.02	OTHER - MISC DIETARY	202,246	24.02
24.03		0	24.03
24.04	OTHER - DONATIONS	12,914	24.04
24.05	OTHER	29,988	24.05
24.06	OTHER	-225,782	24.06
24.07	OTHER-NON CASH FUNDED PENSION CURTAI	544,693	24.07
25.00	Total other income (sum of lines 6-24)	1,215,595	25.00
26.00	Total (line 5 plus line 25)	532,300	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	532,300	29.00