

**ST. VINCENT SALEM HOSPITAL
SALEM, INDIANA**

PROVIDER NOS. 15-1314 AND 15-Z314

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

JUNE 30, 2012

ST. VINCENT SALEM HOSPITAL
PROVIDER NOS. 15-1314 AND 15-Z314

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Accountants' Disclaimer

Hospital Statements of Reimbursable Costs



Bradley Associates
Healthcare Advisors and CPAs

Board of Trustees
St. Vincent Salem Hospital
Salem, Indiana

In accordance with your request, we have compiled the Hospital Statements of Reimbursable Costs (Titles XVIII and XIX) of St. Vincent Salem Hospital (Provider Nos. 15-1314 and 15-Z314) 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 28, 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: 151314	Period: From 07/01/2011 To 06/30/2012	FORM APPROVED OMB NO. 0938-0050 Worksheet S Parts I-III Date/Time Prepared: 11/28/2012 10:21 am
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PART I -- COST REPORT STATUS:

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input checked="" type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 11/28/2012 Time: 10:21 am
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST VINCENT SALEM 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: 11/28/2012 Time: 10:21 am
8wfNmgERgkijw40T1mb21sB4N4Cp0
sYMsD0XqF:r6vqrV3IEXWL3enESMrQ
0Uzj0:qz110P4GjX
PI: Date: 11/28/2012 Time: 10:21 am
5GED9iHIzvsRe966SnbstNuBbd4D10
dmvy202A3Tb2tVbKcWsj7r4LmN2ON
Idq:Et8IA50dr1wE

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

Title

Date

	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III -- SETTLEMENT SUMMARY						
1.00	Hospital	0	218,907	-15,627	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	136,460	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	355,367	-15,627	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: 151314		Period: From 07/01/2011 To 06/30/2012		Worksheet S-2 Part I Date/Time Prepared: 11/28/2012 10:01 am			
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 911 N. SHELBY STREET		PO Box:						
2.00	City: SALEM		State: IN		Zip Code: 47167		County: WASHINGTON		
		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	
Hospital and Hospital-Based Component Identification:									
3.00	Hospital		ST VINCENT SALEM	151314	31140	1	12/01/2002	N O O	
4.00	Subprovider - IPF								
5.00	Subprovider - IRF								
6.00	Subprovider - (Other)								
7.00	Swing Beds - SNF		ST VINCENT SALEM	152314	31140		12/01/2002	N O N	
8.00	Swing Beds - NF							N N	
9.00	Hospital-Based SNF								
10.00	Hospital-Based NF								
11.00	Hospital-Based OLTC								
12.00	Hospital-Based HHA								
13.00	Separately Certified ASC								
14.00	Hospital-Based Hospice								
15.00	Hospital-Based Health Clinic - RHC						N	N N	
16.00	Hospital-Based Health Clinic - FQHC						N	N N	
17.00	Hospital-Based (CMHC) 1								
18.00	Renal Dialysis								
19.00	Other								
						From:	To:		
						1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)					07/01/2011		06/30/2012	
21.00	Type of Control (see instructions)					2			
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	
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	
		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	
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	
						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			
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			
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			
						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.								
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			
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.								

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 151314

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

Worksheet S-2
Part I
Date/Time Prepared:
11/28/2012 10:01 am

		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.				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 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	
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. If line 63 is yes or your facility trained residents in the base year period, enter in column 1, from your cost reporting period that begins on or after July 1, 2009, and before June 30, 2010 the number of unweighted nonprimary care FTE residents attributable to rotations that occurred in all nonprovider settings. Enter in column 2 the number of unweighted nonprimary care FTE residents that trained in your hospital. Include unweighted OB/GYN, dental and podiatry FTEs on this line. Enter in column 3, the ratio of column 1 divided by the sum of columns 1 and 2.		0.00	0.000000	64.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Ratio (col. 3/ (col. 3 + col. 4))
		1.00	2.00	3.00	4.00
				5.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 151314

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

Worksheet S-2
Part I
Date/Time Prepared:
11/28/2012 10:01 am

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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151314	Period: From 07/01/2011 To 06/30/2012	Worksheet S-2 Part I Date/Time Prepared: 11/28/2012 10:01 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		Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			Y	92.00
93.00	Does this facility operate an ICFMR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N		N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N		N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.		0.00		95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.		0.00		97.00
Rural Providers					
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?			Y	105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N			106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)			N	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.	N	N	N	N
		1.00	2.00	3.00	
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.			N	0
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.			N	116.00

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		1.00	2.00	3.00	
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2			118.00
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	Enter the total amount of malpractice premiums paid in column 1, enter the total amount of paid losses in column 2, and enter the total amount of self insurance paid in column 3.	80,311	0	0	118.01
		1.00	2.00		
118.02	Indicate if malpractice premiums and paid losses are reported in other than the Administrative and General cost center. If yes, provide a supporting schedule and list the amounts applicable to each cost center.	N			118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	If this is an SCH (or EACH), regardless of bed size, or is rural hospital with 100 or fewer beds that qualifies for the outpatient hold harmless provision in accordance with ACA, section 3121, as amended by the Medicare and Medicaid Extenders Act (MMEA) of 2010, section 108; the Temporary Payroll Tax Cut Continuation Act of 2011, section 308; and the Middle Class Tax Relief and Job Creation Act of 2012, section 3002, enter "Y" for yes or "N" for no in column 1 or column 2, respectively. Note that for SCHs (and EACHs) the outpatient hold harmless provision is effective for services rendered from January 1, 2010 through February 29, 2012 regardless of bed size and from March 1, 2012 through December 31, 2012 to all SCHs (and EACHs) with 100 or fewer beds. These responses impact the TOPs calculation on Worksheet E, Part B, line 8.	N	N		120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y			121.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	15H046		140.00
		1.00	2.00	3.00	
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.					
141.00	Name: ST VINCENT HEALTH	Contractor's Name: WPS		Contractor's Number: 08101	
142.00	Street: 10330 N. MERIDIAN STREET	PO Box:			
143.00	City: INDIANAPOLIS	State: IN		Zip Code: 46290	
		1.00	2.00		
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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151314		Period: From 07/01/2011 To 06/30/2012		Worksheet S-2 Part I Date/Time Prepared: 11/28/2012 10:01 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
						1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.					N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						0168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.00169.00

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

	Description	Part A			
		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	N			24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N			25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N			26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N			27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N			28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	Y			29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N			30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N			31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N			32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N			33.00
Provider-Based Physicians:					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y			34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	Y			35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?	Y			36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y			37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N			38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N			39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N			40.00
				1.00	2.00
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	GARY	MARKER		41.00
42.00	Enter the employer/company name of the cost report preparer.	ST. VINCENT HEALTH			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-583-3232	GAMARKER@STVINCENT.ORG		43.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151314

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

Worksheet S-3
Part I
Date/Time Prepared:
11/28/2012 10:01 am

Cost Center Description	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	
	Line Number				
	1.00	2.00	3.00	4.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	25	9,150	28,944.00	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	28,944.00	7.00
8.00 INTENSIVE CARE UNIT					8.00
9.00 CORONARY CARE UNIT					9.00
10.00 BURN INTENSIVE CARE UNIT					10.00
11.00 SURGICAL INTENSIVE CARE UNIT					11.00
12.00 OTHER SPECIAL CARE (SPECIFY)					12.00
13.00 NURSERY					13.00
14.00 Total (see instructions)		25	9,150	28,944.00	14.00
15.00 CAH visits					15.00
16.00 SUBPROVIDER - IPF					16.00
17.00 SUBPROVIDER - IRF					17.00
18.00 SUBPROVIDER					18.00
19.00 SKILLED NURSING FACILITY					19.00
20.00 NURSING FACILITY					20.00
21.00 OTHER LONG TERM CARE					21.00
22.00 HOME HEALTH AGENCY					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)					23.00
24.00 HOSPICE					24.00
25.00 CMHC - CMHC					25.00
26.00 RURAL HEALTH CLINIC	88.00				26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				26.25
27.00 Total (sum of lines 14-26)		25			27.00
28.00 Observation Bed Days					28.00
29.00 Ambulance Trips					29.00
30.00 Employee discount days (see instruction)					30.00
31.00 Employee discount days - IRF					31.00
32.00 Labor & delivery days (see instructions)					32.00
33.00 LTCH non-covered days					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151314

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

Worksheet S-3
Part I
Date/Time Prepared:
11/28/2012 10:01 am

Cost Center Description	I/P Days / O/P Visits / Trips				Total All Patients	
	Title V	Title XVIII	Title XIX			
	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	683	33	1,206	1.00	
2.00 HMO		200	41		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	371	0	371	5.00	
6.00 Hospital Adults & Peds. Swing Bed NF	0		0	52	6.00	
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	0	1,054	33	1,629	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	1,054	33	1,629	14.00	
15.00 CAH visits	0	0	0	0	15.00	
16.00 SUBPROVIDER - IPF					16.00	
17.00 SUBPROVIDER - IRF					17.00	
18.00 SUBPROVIDER					18.00	
19.00 SKILLED NURSING FACILITY					19.00	
20.00 NURSING FACILITY					20.00	
21.00 OTHER LONG TERM CARE					21.00	
22.00 HOME HEALTH AGENCY					22.00	
23.00 AMBULATORY SURGICAL CENTER (D.P.)					23.00	
24.00 HOSPICE					24.00	
25.00 CMHC - CMHC					25.00	
26.00 RURAL HEALTH CLINIC	0	0	0	0	26.00	
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	26.25	
27.00 Total (sum of lines 14-26)					27.00	
28.00 Observation Bed Days	0		0	353	28.00	
29.00 Ambulance Trips		0			29.00	
30.00 Employee discount days (see instruction)				4	30.00	
31.00 Employee discount days - IRF				0	31.00	
32.00 Labor & delivery days (see instructions)			0	0	32.00	
33.00 LTCH non-covered days		0			33.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151314

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

Worksheet S-3
Part I
Date/Time Prepared:
11/28/2012 10:01 am

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	228	1.00
2.00 HMO					62	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	137.72	0.00	0	228	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	0.00	0.00	0.00			26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00	0.00	0.00			26.25
27.00 Total (sum of lines 14-26)	0.00	137.72	0.00			27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151314

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

Worksheet S-3
Part I
Date/Time Prepared:
11/28/2012 10:01 am

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)	38	390	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)	38	390	14.00
15.00 CAH visits			15.00
16.00 SUBPROVIDER - IPF			16.00
17.00 SUBPROVIDER - IRF			17.00
18.00 SUBPROVIDER			18.00
19.00 SKILLED NURSING FACILITY			19.00
20.00 NURSING FACILITY			20.00
21.00 OTHER LONG TERM CARE			21.00
22.00 HOME HEALTH AGENCY			22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)			23.00
24.00 HOSPICE			24.00
25.00 CMHC - CMHC			25.00
26.00 RURAL HEALTH CLINIC			26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER			26.25
27.00 Total (sum of lines 14-26)			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 I line 200 column 3 divided by line 200 column 8)	0.382103	1.00
Medicaid (see instructions for each line)			
2.00	Net revenue from Medicaid	1,387,114	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	7,587,088	6.00
7.00	Medicaid cost (line 1 times line 6)	2,899,049	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)	1,511,935	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	37,032	18.00
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	1,511,935	19.00
		Uninsured patients	Insured patients
		1.00	2.00
		Total (col. 1 + col. 2)	
		3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	1,922,235	0
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	734,492	0
22.00	Partial payment by patients approved for charity care	0	0
23.00	Cost of charity care (line 21 minus line 22)	734,492	0
		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	3,534,757	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	493,187	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)	3,041,570	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)	1,162,193	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)	1,896,685	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	3,408,620	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151314

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

Worksheet A

Date/Time Prepared:
11/28/2012 10:01 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)		
		1.00	2.00	3.00	4.00	5.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		420,734	420,734	0	420,734	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	0	0	2.00
3.00	00300	OTHER CAP RELATED COST		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS	158,582	2,004,257	2,162,839	0	2,162,839	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,625,732	2,591,672	4,217,404	0	4,217,404	5.00
7.00	00700	OPERATION OF PLANT	174,335	1,174,928	1,349,263	0	1,349,263	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	124,247	72,322	196,569	0	196,569	9.00
10.00	01000	DIETARY	165,674	125,285	290,959	-233,171	57,788	10.00
11.00	01100	CAFETERIA	0	0	0	233,171	233,171	11.00
13.00	01300	NURSING ADMINISTRATION	71,082	3,720	74,802	0	74,802	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	94,701	9,032	103,733	0	103,733	14.00
15.00	01500	PHARMACY	190,305	70,342	260,647	0	260,647	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	266,180	17,493	283,673	0	283,673	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	853,883	61,240	915,123	0	915,123	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	668,532	311,816	980,348	0	980,348	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	618,461	326,366	944,827	0	944,827	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	53,607	258,758	312,365	0	312,365	58.00
60.00	06000	LABORATORY	17	1,525,397	1,525,414	0	1,525,414	60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY		0	0	0	0	61.00
65.00	06500	RESPIRATORY THERAPY	229,026	14,770	243,796	0	243,796	65.00
66.00	06600	PHYSICAL THERAPY	429,088	10,055	439,143	0	439,143	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	202,445	7,155	209,600	0	209,600	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	335,602	335,602	0	335,602	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	516,574	516,574	0	516,574	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	267,440	267,440	0	267,440	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
75.01	03950	SLEEP DISORDER	142,907	73,497	216,404	0	216,404	75.01
75.02	03951	NEW HORIZON OP	23,995	202	24,197	0	24,197	75.02
75.03	07501	ADULT MENTAL HEALTH	0	31,775	31,775	0	31,775	75.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	802,050	1,119,428	1,921,478	0	1,921,478	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)	6,894,849	11,349,860	18,244,709	0	18,244,709	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	75,257	3,395	78,652	0	78,652	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MARKETING/ PUBLIC RELATIONS	65,873	5,454	71,327	0	71,327	193.01
200.00		TOTAL (SUM OF LINES 118-199)	7,035,979	11,358,709	18,394,688	0	18,394,688	200.00

Cost Center Description		Adjustments (See A-8) 6.00	Net Expenses For Allocation 7.00		
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	231,011	651,745	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	499,410	2,662,249	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-11,569	4,205,835	5.00
7.00	00700	OPERATION OF PLANT	44,692	1,393,955	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	8.00
9.00	00900	HOUSEKEEPING	0	196,569	9.00
10.00	01000	DIETARY	0	57,788	10.00
11.00	01100	CAFETERIA	-65,936	167,235	11.00
13.00	01300	NURSING ADMINISTRATION	0	74,802	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	103,733	14.00
15.00	01500	PHARMACY	0	260,647	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-6,914	276,759	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-58,000	857,123	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-71,656	908,692	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	-195,883	748,944	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	312,365	58.00
60.00	06000	LABORATORY	0	1,525,414	60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0	61.00
65.00	06500	RESPIRATORY THERAPY	0	243,796	65.00
66.00	06600	PHYSICAL THERAPY	-20	439,123	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	209,600	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	335,602	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	516,574	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	267,440	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	75.00
75.01	03950	SLEEP DISORDER	-51,600	164,804	75.01
75.02	03951	NEW HORIZON OP	0	24,197	75.02
75.03	07501	ADULT MENTAL HEALTH	0	31,775	75.03
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	-150,000	1,771,478	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	163,535	18,408,244	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	78,652	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
193.01	19301	MARKETING/ PUBLIC RELATIONS	261,797	333,124	193.01
200.00		TOTAL (SUM OF LINES 118-199)	425,332	18,820,020	200.00

Provider CCN: 151314

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

Worksheet A-6
Date/Time Prepared:
11/28/2012 10:01 am

		Increases				
		Cost Center	Line #	Salary	Other	
		2.00	3.00	4.00	5.00	
A - CAFETERIA						
1.00	CAFETERIA		11.00	132,769	100,402	1.00
	TOTALS			132,769	100,402	
500.00	Grand Total: Increases			132,769	100,402	500.00

Provider CCN: 151314

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

Worksheet A-6

Date/Time Prepared:
11/28/2012 10:01 am

		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	132,769	100,402	0		1.00
	TOTALS		132,769	100,402			
500.00	Grand Total: Decreases		132,769	100,402			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151314

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
11/28/2012 10:01 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	0	0	0	0	0	1.00
2.00 Land Improvements	0	0	0	0	0	2.00
3.00 Buildings and Fixtures	88,109	0	0	0	88,109	3.00
4.00 Building Improvements	0	795,856	0	795,856	0	4.00
5.00 Fixed Equipment	0	495,809	0	495,809	0	5.00
6.00 Movable Equipment	248,189	61,908	0	61,908	0	6.00
7.00 HIT designated Assets	0	0	0	0	0	7.00
8.00 Subtotal (sum of lines 1-7)	336,298	1,353,573	0	1,353,573	88,109	8.00
9.00 Reconciling Items	0	0	0	0	0	9.00
10.00 Total (line 8 minus line 9)	336,298	1,353,573	0	1,353,573	88,109	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	0	399,120	0	21,614	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	399,120	0	21,614	0	3.00
COMPUTATION OF RATIOS						
Cost Center Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL Ratio (see instructions)	Insurance	
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00 CAP REL COSTS-BLDG & FIXT	1,601,762	0	1,601,762	1.000000	0	1.00
2.00 CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00 Total (sum of lines 1-2)	1,601,762	0	1,601,762	1.000000	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151314

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
11/28/2012 10:01 am

		Ending Balance	Fully Depreciated Assets			
		6.00	7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0			1.00
2.00	Land Improvements	0	0			2.00
3.00	Buildings and Fixtures	0	0			3.00
4.00	Building Improvements	795,856	0			4.00
5.00	Fixed Equipment	495,809	0			5.00
6.00	Movable Equipment	310,097	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	1,601,762	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	1,601,762	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	420,734			1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0			2.00
3.00	Total (sum of lines 1-2)	0	420,734			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	231,011	399,120
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0
3.00	Total (sum of lines 1-2)	0	0	0	231,011	399,120

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151314

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
11/28/2012 10:01 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	21,614	0	0	651,745	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	21,614	0	0	651,745	3.00

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on worksheet A To/From which the Amount is to be Adjusted	
			Cost Center	Line #
	1.00	2.00	3.00	4.00
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00 1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00 2.00
3.00 Investment income - other (chapter 2)		0		0.00 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)		0		0.00 8.00
9.00 Parking lot (chapter 21)		0		0.00 9.00
10.00 Provider-based physician adjustment	A-8-2	-526,570		10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0		0.00 11.00
12.00 Related organization transactions (chapter 10)	A-8-1	1,050,910		12.00
13.00 Laundry and linen service		0		0.00 13.00
14.00 Cafeteria-employees and guests	B	-65,936	CAFETERIA	11.00 14.00
15.00 Rental of quarters to employee and others		0		0.00 15.00
16.00 Sale of medical and surgical supplies to other than patients		0		0.00 16.00
17.00 Sale of drugs to other than patients		0		0.00 17.00
18.00 Sale of medical records and abstracts	B	-20,614	MEDICAL RECORDS & LIBRARY	16.00 18.00
19.00 Nursing school (tuition, fees, books, etc.)		0		0.00 19.00
20.00 Vending machines		0		0.00 20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00 21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00 22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00 23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00 24.00
25.00 Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00 25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00 26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00 27.00
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 DONATIONS AND CHARITABLE EXPENSES	A	-1,550	ADMINISTRATIVE & GENERAL	5.00 33.00
33.01 OTHER REVENUE - ADMINISTRATION	B	-6,529	ADMINISTRATIVE & GENERAL	5.00 33.01
33.02 ASSOCIATION DUES LOBBYING EXPENSE OF	A	-823	ADMINISTRATIVE & GENERAL	5.00 33.02
33.03 OTHER REVENUE - RADIOLOGY	B	-569	RADIOLOGY - DIAGNOSTIC	54.00 33.03
33.04 MED RECORDS FOR SPN	A	13,700	MEDICAL RECORDS & LIBRARY	16.00 33.04
33.05 OTHER REVENUE - PT	B	-20	PHYSICAL THERAPY	66.00 33.05
33.06 INCENTIVE ADJUSTMENT - SALARY	A	-16,667	ADMINISTRATIVE & GENERAL	5.00 33.06
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		425,332		50.00

Cost Center Description	Wkst. A-7 Ref.	
	5.00	
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	0	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 DONATIONS AND CHARITABLE EXPENSES	0	33.00
33.01 OTHER REVENUE - ADMINISTRATION	0	33.01
33.02 ASSOCIATION DUES LOBBYING EXPENSE OF	0	33.02
33.03 OTHER REVENUE - RADIOLOGY	0	33.03
33.04 MED RECORDS FOR SPN	0	33.04
33.05 OTHER REVENUE - PT	0	33.05
33.06 INCENTIVE ADJUSTMENT - SALARY	0	33.06
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: 151314

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

Worksheet A-8-1

Date/Time Prepared:
11/28/2012 10:01 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		4.00	EMPLOYEE BENEFITS	SVH - SELF-INSURANCE	1.00
2.00		1.00	CAP REL COSTS-BLDG & FIXT	SVH - CAPITAL	2.00
3.00		193.01	MARKETING/ PUBLIC RELATIONS	SVH - MARKETING	3.00
4.00		5.00	ADMINISTRATIVE & GENERAL	SVH - NON-CAPITAL	4.00
4.01		4.00	EMPLOYEE BENEFITS	DIRECT CHARGEBACKS - BENEFITS	4.01
4.02		5.00	ADMINISTRATIVE & GENERAL	DIRECT CHARGEBACKS - A&G	4.02
4.03		7.00	OPERATION OF PLANT	DIRECT CHARGEBACKS - PLANT OPS	4.03
4.04		13.00	NURSING ADMINISTRATION	DIRECT CHARGEBACKS - NURSING ADMIN	4.04
4.05		14.00	CENTRAL SERVICES & SUPPLY	DIRECT CHARGEBACKS - SUPPLY	4.05
4.06		16.00	MEDICAL RECORDS & LIBRARY	DIRECT CHARGEBACKS - MED REC	4.06
4.07		54.00	RADIOLOGY - DIAGNOSTIC	DIRECT CHARGEBACKS - RADIOLOGY	4.07
4.08		91.00	EMERGENCY	DIRECT CHARGEBACKS - EMERGENCY	4.08
4.09		7.00	OPERATION OF PLANT	ASCENSION - TRIMEDX	4.09
4.10		4.00	EMPLOYEE BENEFITS	ASCENSION - PENSION	4.10
4.11		0.00			4.11
4.12		0.00			4.12
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	ASCENSION HEALT	100.00	6.00
7.00		G	ST VINCENT HEAL	100.00	7.00
8.00		G	CATHOLIC HEALTH	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:		HOME OFFICE		100.00

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

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

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

Provider CCN: 151314

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

Worksheet A-8-1

Date/Time Prepared:
11/28/2012 10:01 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	1,399,768	900,358	499,410	0	1.00
2.00	231,011	0	231,011	9	2.00
3.00	261,797	0	261,797	0	3.00
4.00	1,332,499	1,318,499	14,000	0	4.00
4.01	76,996	76,996	0	0	4.01
4.02	468,819	468,819	0	0	4.02
4.03	77,817	77,817	0	0	4.03
4.04	1,260	1,260	0	0	4.04
4.05	26,795	26,795	0	0	4.05
4.06	16,080	16,080	0	0	4.06
4.07	7,420	7,420	0	0	4.07
4.08	230	230	0	0	4.08
4.09	451,465	406,773	44,692	0	4.09
4.10	271,713	271,713	0	0	4.10
4.11	0	0	0	0	4.11
4.12	0	0	0	0	4.12
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.	4,623,670	3,572,760	1,050,910	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	ASCENSION HEALT	100.00	HOME OFFICE	6.00
7.00	ST VINCENT HEAL	100.00	HOME OFFICE	7.00
8.00	CATHOLIC HEALTH	100.00	HOME OFFICE	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: 151314

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

Worksheet A-8-2

Date/Time Prepared:
11/28/2012 10:01 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
	1.00	2.00	3.00	4.00	
1.00	91.00	EMERGENCY	1,054,095	150,000	1.00
2.00	30.00	ADULTS & PEDIATRICS	58,042	58,000	2.00
3.00	50.00	OPERATING ROOM	71,656	71,656	3.00
4.00	54.00	RADIOLOGY - DIAGNOSTIC	250,766	195,314	4.00
5.00	60.00	LABORATORY	31,015	0	5.00
6.00	75.01	SLEEP DISORDER	51,600	51,600	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			1,517,174	526,570	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151314

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

Worksheet A-8-2

Date/Time Prepared:
11/28/2012 10:01 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	904,095	0	0	0	0	1.00
2.00	42	0	0	0	0	2.00
3.00	0	0	0	0	0	3.00
4.00	55,452	0	0	0	0	4.00
5.00	31,015	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	990,604					200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151314

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

Worksheet A-8-2

Date/Time Prepared:
11/28/2012 10:01 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: 151314

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

Worksheet A-8-2
Date/Time Prepared:
11/28/2012 10:01 am

	RCE	Adjustment	
	Disallowance		
	17.00	18.00	
1.00	0	150,000	1.00
2.00	0	58,000	2.00
3.00	0	71,656	3.00
4.00	0	195,314	4.00
5.00	0	0	5.00
6.00	0	51,600	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	526,570	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151314

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

Worksheet B
Part I
Date/Time Prepared:
11/28/2012 10:01 am

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	651,745	651,745			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	0		0		2.00
4.00 00400	EMPLOYEE BENEFITS	2,662,249	1,394	0	2,663,643	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	4,205,835	111,675	0	629,654	4,947,164 5.00
7.00 00700	OPERATION OF PLANT	1,393,955	110,334	0	67,521	1,571,810 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	15,243	0	0	15,243 8.00
9.00 00900	HOUSEKEEPING	196,569	5,909	0	48,121	250,599 9.00
10.00 01000	DIETARY	57,788	55,428	0	12,744	125,960 10.00
11.00 01100	CAFETERIA	167,235	0	0	51,422	218,657 11.00
13.00 01300	NURSING ADMINISTRATION	74,802	1,246	0	27,530	103,578 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	103,733	16,594	0	36,678	157,005 14.00
15.00 01500	PHARMACY	260,647	6,510	0	73,706	340,863 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	276,759	13,003	0	103,093	392,855 16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	857,123	54,435	0	330,712	1,242,270 30.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	908,692	72,833	0	258,925	1,240,450 50.00
54.00 05400	RADIOLOGY - DIAGNOSTIC	748,944	32,438	0	239,532	1,020,914 54.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	312,365	8,088	0	20,762	341,215 58.00
60.00 06000	LABORATORY	1,525,414	18,459	0	7	1,543,880 60.00
61.00 06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0				0 61.00
65.00 06500	RESPIRATORY THERAPY	243,796	3,660	0	88,703	336,159 65.00
66.00 06600	PHYSICAL THERAPY	439,123	19,984	0	166,187	625,294 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	209,600	8,611	0	78,408	296,619 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	335,602	0	0	0	335,602 71.00
72.00 07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	516,574	0	0	0	516,574 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	267,440	0	0	0	267,440 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
75.01 03950	SLEEP DISORDER	164,804	17,352	0	55,348	237,504 75.01
75.02 03951	NEW HORIZON OP	24,197	6,597	0	9,293	40,087 75.02
75.03 07501	ADULT MENTAL HEALTH	31,775	2,998	0	0	34,773 75.03
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	0 88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0 89.00
90.00 09000	CLINIC	0	0	0	0	0 90.00
91.00 09100	EMERGENCY	1,771,478	27,775	0	310,637	2,109,890 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0 92.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	18,408,244	610,566	0	2,608,983	18,312,405 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0 190.00
191.00 19100	RESEARCH	0	0	0	0	0 191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	78,652	33,606	0	29,147	141,405 192.00
193.00 19300	NONPAID WORKERS	0	0	0	0	0 193.00
193.01 19301	MARKETING/ PUBLIC RELATIONS	333,124	7,573	0	25,513	366,210 193.01
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)	18,820,020	651,745	0	2,663,643	18,820,020 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151314

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

Worksheet B
Part I
Date/Time Prepared:
11/28/2012 10:01 am

Cost Center Description		ADMINISTRATIVE & GENERAL 5.00	OPERATION OF PLANT 7.00	LAUNDRY & LINEN SERVICE 8.00	HOUSEKEEPING 9.00	DIETARY 10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500	4,947,164					5.00
7.00	00700	560,518	2,132,328				7.00
8.00	00800	5,436	75,880	96,559			8.00
9.00	00900	89,365	29,415	3,678	373,057		9.00
10.00	01000	44,918	275,928	2,089	0	448,895	10.00
11.00	01100	77,975	0	0	0	0	11.00
13.00	01300	36,937	6,204	0	0	0	13.00
14.00	01400	55,989	82,605	0	4,293	0	14.00
15.00	01500	121,554	32,409	0	0	0	15.00
16.00	01600	140,095	64,730	0	6,654	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	443,002	270,983	27,135	96,378	448,895	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	442,353	362,570	16,017	91,225	0	50.00
54.00	05400	364,065	161,479	8,748	27,260	0	54.00
58.00	05800	121,680	40,261	0	0	0	58.00
60.00	06000	550,558	91,889	0	18,460	0	60.00
61.00	06100						61.00
65.00	06500	119,877	18,222	0	0	0	65.00
66.00	06600	222,984	99,482	8,969	10,303	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	105,776	42,864	1,616	16,957	0	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	119,678	0	0	0	0	71.00
72.00	07200	184,214	0	0	0	0	72.00
73.00	07300	95,371	0	0	6,225	0	73.00
74.00	07400	0	0	0	0	0	74.00
75.00	07500	0	0	0	0	0	75.00
75.01	03950	84,696	86,379	2,968	14,596	0	75.01
75.02	03951	14,295	32,842	0	2,146	0	75.02
75.03	07501	12,400	14,924	0	0	0	75.03
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	0	0	0	0	0	90.00
91.00	09100	752,409	138,268	25,233	66,755	0	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
118.00		4,766,145	1,927,334	96,453	361,252	448,895	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	2,146	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	50,426	167,292	106	9,659	0	192.00
193.00	19300	0	0	0	0	0	193.00
193.01	19301	130,593	37,702	0	0	0	193.01
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		4,947,164	2,132,328	96,559	373,057	448,895	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151314

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

Worksheet B
Part I
Date/Time Prepared:
11/28/2012 10:01 am

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	296,632					11.00
13.00	01300	5,517	152,236				13.00
14.00	01400	8,975	0	308,867			14.00
15.00	01500	7,137	0	0	501,963		15.00
16.00	01600	25,707	0	0	0	630,041	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	53,365	23,516	0	0	75,114	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	34,569	24,752	0	0	113,055	50.00
54.00	05400	38,376	13,615	0	0	115,354	54.00
58.00	05800	3,028	1,238	0	0	0	58.00
60.00	06000	2	9,902	0	0	0	60.00
61.00	06100						61.00
65.00	06500	15,581	4,951	0	0	0	65.00
66.00	06600	23,033	17,328	0	0	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	13,502	6,188	0	0	0	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	302,123	0	0	71.00
72.00	07200	0	0	6,744	0	0	72.00
73.00	07300	0	19,803	0	501,963	0	73.00
74.00	07400	0	0	0	0	0	74.00
75.00	07500	0	0	0	0	0	75.00
75.01	03950	10,511	0	0	0	0	75.01
75.02	03951	1,689	0	0	0	0	75.02
75.03	07501	0	0	0	0	0	75.03
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	0	0	0	0	0	90.00
91.00	09100	46,399	21,041	0	0	195,834	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
118.00		287,391	142,334	308,867	501,963	499,357	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	5,930	9,902	0	0	130,684	192.00
193.00	19300	0	0	0	0	0	193.00
193.01	19301	3,311	0	0	0	0	193.01
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		296,632	152,236	308,867	501,963	630,041	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151314

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

Worksheet B
Part I
Date/Time Prepared:
11/28/2012 10:01 am

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100				1.00
2.00	00200				2.00
4.00	00400				4.00
5.00	00500				5.00
7.00	00700				7.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
13.00	01300				13.00
14.00	01400				14.00
15.00	01500				15.00
16.00	01600				16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	2,680,658	0	2,680,658	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	2,324,991	0	2,324,991	50.00
54.00	05400	1,749,811	0	1,749,811	54.00
58.00	05800	507,422	0	507,422	58.00
60.00	06000	2,214,691	0	2,214,691	60.00
61.00	06100	0	0	0	61.00
65.00	06500	494,790	0	494,790	65.00
66.00	06600	1,007,393	0	1,007,393	66.00
67.00	06700	0	0	0	67.00
68.00	06800	0	0	0	68.00
69.00	06900	483,522	0	483,522	69.00
70.00	07000	0	0	0	70.00
71.00	07100	757,403	0	757,403	71.00
72.00	07200	707,532	0	707,532	72.00
73.00	07300	890,802	0	890,802	73.00
74.00	07400	0	0	0	74.00
75.00	07500	0	0	0	75.00
75.01	03950	436,654	0	436,654	75.01
75.02	03951	91,059	0	91,059	75.02
75.03	07501	62,097	0	62,097	75.03
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	0	0	0	88.00
89.00	08900	0	0	0	89.00
90.00	09000	0	0	0	90.00
91.00	09100	3,355,829	0	3,355,829	91.00
92.00	09200	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS					
118.00		17,764,654	0	17,764,654	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	2,146	0	2,146	190.00
191.00	19100	0	0	0	191.00
192.00	19200	515,404	0	515,404	192.00
193.00	19300	0	0	0	193.00
193.01	19301	537,816	0	537,816	193.01
200.00		0	0	0	200.00
201.00		0	0	0	201.00
202.00		18,820,020	0	18,820,020	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151314

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

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Part II
Date/Time Prepared:
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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	493	1,394	0	1,887
5.00 00500	ADMINISTRATIVE & GENERAL	439,507	111,675	0	551,182
7.00 00700	OPERATION OF PLANT	196,347	110,334	0	306,681
8.00 00800	LAUNDRY & LINEN SERVICE	0	15,243	0	15,243
9.00 00900	HOUSEKEEPING	0	5,909	0	5,909
10.00 01000	DIETARY	1,112	55,428	0	56,540
11.00 01100	CAFETERIA	0	0	0	0
13.00 01300	NURSING ADMINISTRATION	493	1,246	0	1,739
14.00 01400	CENTRAL SERVICES & SUPPLY	1,644	16,594	0	18,238
15.00 01500	PHARMACY	25,010	6,510	0	31,520
16.00 01600	MEDICAL RECORDS & LIBRARY	4,523	13,003	0	17,526
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 03000	ADULTS & PEDIATRICS	18,179	54,435	0	72,614
ANCILLARY SERVICE COST CENTERS					
50.00 05000	OPERATING ROOM	36,017	72,833	0	108,850
54.00 05400	RADIOLOGY - DIAGNOSTIC	1,285	32,438	0	33,723
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	198,030	8,088	0	206,118
60.00 06000	LABORATORY	1,235	18,459	0	19,694
61.00 06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0	0	0
65.00 06500	RESPIRATORY THERAPY	1,008	3,660	0	4,668
66.00 06600	PHYSICAL THERAPY	591	19,984	0	20,575
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0
68.00 06800	SPEECH PATHOLOGY	0	0	0	0
69.00 06900	ELECTROCARDIOLOGY	1,926	8,611	0	10,537
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0
72.00 07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0
74.00 07400	RENAL DIALYSIS	0	0	0	0
75.00 07500	ASC (NON-DISTINCT PART)	0	0	0	0
75.01 03950	SLEEP DISORDER	7,929	17,352	0	25,281
75.02 03951	NEW HORIZON OP	0	6,597	0	6,597
75.03 07501	ADULT MENTAL HEALTH	0	2,998	0	2,998
OUTPATIENT SERVICE COST CENTERS					
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0
90.00 09000	CLINIC	0	0	0	0
91.00 09100	EMERGENCY	6,495	27,775	0	34,270
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0
SPECIAL PURPOSE COST CENTERS					
118.00	SUBTOTALS (SUM OF LINES 1-117)	941,824	610,566	0	1,552,390
NONREIMBURSABLE COST CENTERS					
190.00 19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0
191.00 19100	RESEARCH	0	0	0	0
192.00 19200	PHYSICIANS' PRIVATE OFFICES	987	33,606	0	34,593
193.00 19300	NONPAID WORKERS	0	0	0	0
193.01 19301	MARKETING/ PUBLIC RELATIONS	1,634	7,573	0	9,207
200.00	Cross Foot Adjustments	0	0	0	0
201.00	Negative Cost Centers	0	0	0	0
202.00	TOTAL (sum lines 118-201)	944,445	651,745	0	1,596,190

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151314

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Cost Center Description		ADMINISTRATIVE & GENERAL 5.00	OPERATION OF PLANT 7.00	LAUNDRY & LINEN SERVICE 8.00	HOUSEKEEPING 9.00	DIETARY 10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500	551,630					5.00
7.00	00700	62,500	369,229				7.00
8.00	00800	606	13,139	28,988			8.00
9.00	00900	9,965	5,093	1,104	22,105		9.00
10.00	01000	5,009	47,779	627	0	109,964	10.00
11.00	01100	8,694	0	0	0	0	11.00
13.00	01300	4,119	1,074	0	0	0	13.00
14.00	01400	6,243	14,304	0	254	0	14.00
15.00	01500	13,554	5,612	0	0	0	15.00
16.00	01600	15,621	11,209	0	394	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	49,396	46,923	8,147	5,713	109,964	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	49,324	62,783	4,808	5,405	0	50.00
54.00	05400	40,595	27,961	2,626	1,615	0	54.00
58.00	05800	13,568	6,972	0	0	0	58.00
60.00	06000	61,389	15,911	0	1,094	0	60.00
61.00	06100						61.00
65.00	06500	13,367	3,155	0	0	0	65.00
66.00	06600	24,864	17,226	2,693	610	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	11,794	7,422	485	1,005	0	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	13,345	0	0	0	0	71.00
72.00	07200	20,541	0	0	0	0	72.00
73.00	07300	10,634	0	0	369	0	73.00
74.00	07400	0	0	0	0	0	74.00
75.00	07500	0	0	0	0	0	75.00
75.01	03950	9,444	14,957	891	865	0	75.01
75.02	03951	1,594	5,687	0	127	0	75.02
75.03	07501	1,383	2,584	0	0	0	75.03
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	0	0	0	0	0	90.00
91.00	09100	83,896	23,942	7,575	3,955	0	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
118.00		531,445	333,733	28,956	21,406	109,964	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	127	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	5,623	28,968	32	572	0	192.00
193.00	19300	0	0	0	0	0	193.00
193.01	19301	14,562	6,528	0	0	0	193.01
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		551,630	369,229	28,988	22,105	109,964	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151314

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

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	8,730					11.00
13.00	01300	162	7,113				13.00
14.00	01400	264	0	39,329			14.00
15.00	01500	210	0	0	50,948		15.00
16.00	01600	757	0	0	0	45,580	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	1,571	1,099	0	0	5,434	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	1,017	1,156	0	0	8,179	50.00
54.00	05400	1,129	636	0	0	8,345	54.00
58.00	05800	89	58	0	0	0	58.00
60.00	06000	0	463	0	0	0	60.00
61.00	06100						61.00
65.00	06500	459	231	0	0	0	65.00
66.00	06600	678	810	0	0	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	397	289	0	0	0	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	38,470	0	0	71.00
72.00	07200	0	0	859	0	0	72.00
73.00	07300	0	925	0	50,948	0	73.00
74.00	07400	0	0	0	0	0	74.00
75.00	07500	0	0	0	0	0	75.00
75.01	03950	309	0	0	0	0	75.01
75.02	03951	50	0	0	0	0	75.02
75.03	07501	0	0	0	0	0	75.03
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	0	0	0	0	0	90.00
91.00	09100	1,366	983	0	0	14,168	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
118.00		8,458	6,650	39,329	50,948	36,126	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	175	463	0	0	9,454	192.00
193.00	19300	0	0	0	0	0	193.00
193.01	19301	97	0	0	0	0	193.01
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		8,730	7,113	39,329	50,948	45,580	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151314

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

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100				1.00
2.00	00200				2.00
4.00	00400				4.00
5.00	00500				5.00
7.00	00700				7.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
13.00	01300				13.00
14.00	01400				14.00
15.00	01500				15.00
16.00	01600				16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	301,095	0	301,095	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	241,705	0	241,705	50.00
54.00	05400	116,799	0	116,799	54.00
58.00	05800	226,820	0	226,820	58.00
60.00	06000	98,551	0	98,551	60.00
61.00	06100				61.00
65.00	06500	21,943	0	21,943	65.00
66.00	06600	67,574	0	67,574	66.00
67.00	06700	0	0	0	67.00
68.00	06800	0	0	0	68.00
69.00	06900	31,984	0	31,984	69.00
70.00	07000	0	0	0	70.00
71.00	07100	51,815	0	51,815	71.00
72.00	07200	21,400	0	21,400	72.00
73.00	07300	62,876	0	62,876	73.00
74.00	07400	0	0	0	74.00
75.00	07500	0	0	0	75.00
75.01	03950	51,786	0	51,786	75.01
75.02	03951	14,062	0	14,062	75.02
75.03	07501	6,965	0	6,965	75.03
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	0	0	0	88.00
89.00	08900	0	0	0	89.00
90.00	09000	0	0	0	90.00
91.00	09100	170,375	0	170,375	91.00
92.00	09200	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS					
118.00		1,485,750	0	1,485,750	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	127	0	127	190.00
191.00	19100	0	0	0	191.00
192.00	19200	79,901	0	79,901	192.00
193.00	19300	0	0	0	193.00
193.01	19301	30,412	0	30,412	193.01
200.00		0	0	0	200.00
201.00		0	0	0	201.00
202.00		1,596,190	0	1,596,190	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151314

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	74,783				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		74,783			2.00
4.00 00400	EMPLOYEE BENEFITS	160	160	6,877,397		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	12,814	12,814	1,625,732	-4,947,164	13,872,856 5.00
7.00 00700	OPERATION OF PLANT	12,660	12,660	174,335	0	1,571,810 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	1,749	1,749	0	0	15,243 8.00
9.00 00900	HOUSEKEEPING	678	678	124,247	0	250,599 9.00
10.00 01000	DIETARY	6,360	6,360	32,905	0	125,960 10.00
11.00 01100	CAFETERIA	0	0	132,769	0	218,657 11.00
13.00 01300	NURSING ADMINISTRATION	143	143	71,082	0	103,578 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	1,904	1,904	94,701	0	157,005 14.00
15.00 01500	PHARMACY	747	747	190,305	0	340,863 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	1,492	1,492	266,180	0	392,855 16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	6,246	6,246	853,883	0	1,242,270 30.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	8,357	8,357	668,532	0	1,240,450 50.00
54.00 05400	RADIOLOGY - DIAGNOSTIC	3,722	3,722	618,461	0	1,020,914 54.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	928	928	53,607	0	341,215 58.00
60.00 06000	LABORATORY	2,118	2,118	17	0	1,543,880 60.00
61.00 06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY				0	0 61.00
65.00 06500	RESPIRATORY THERAPY	420	420	229,026	0	336,159 65.00
66.00 06600	PHYSICAL THERAPY	2,293	2,293	429,088	0	625,294 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	988	988	202,445	0	296,619 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	335,602 71.00
72.00 07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	516,574 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	267,440 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
75.01 03950	SLEEP DISORDER	1,991	1,991	142,907	0	237,504 75.01
75.02 03951	NEW HORIZON OP	757	757	23,995	0	40,087 75.02
75.03 07501	ADULT MENTAL HEALTH	344	344	0	0	34,773 75.03
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	0 88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0 89.00
90.00 09000	CLINIC	0	0	0	0	0 90.00
91.00 09100	EMERGENCY	3,187	3,187	802,050	0	2,109,890 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					0 92.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	70,058	70,058	6,736,267	-4,947,164	13,365,241 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0 190.00
191.00 19100	RESEARCH	0	0	0	0	0 191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	3,856	3,856	75,257	0	141,405 192.00
193.00 19300	NONPAID WORKERS	0	0	0	0	0 193.00
193.01 19301	MARKETING/ PUBLIC RELATIONS	869	869	65,873	0	366,210 193.01
200.00	Cross Foot Adjustments					0 200.00
201.00	Negative Cost Centers					0 201.00
202.00	Cost to be allocated (per wkst. B, Part I)	651,745	0	2,663,643		4,947,164 202.00
203.00	Unit cost multiplier (wkst. B, Part I)	8.715149	0.000000	0.387304		0.356607 203.00
204.00	Cost to be allocated (per wkst. B, Part II)			1,887		551,630 204.00
205.00	Unit cost multiplier (wkst. B, Part II)			0.000274		0.039763 205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151314

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS)	
		7.00	8.00	9.00	10.00	11.00	
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
7.00	00700	OPERATION OF PLANT	49,149				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,749	21,866			8.00
9.00	00900	HOUSEKEEPING	678	833	1,738		9.00
10.00	01000	DIETARY	6,360	473	0	1,548	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	143	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,904	0	20	0	14.00
15.00	01500	PHARMACY	747	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,492	0	31	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	6,246	6,145	449	1,548	33,737
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	8,357	3,627	425	0	21,854
54.00	05400	RADIOLOGY - DIAGNOSTIC	3,722	1,981	127	0	24,261
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	928	0	0	0	1,914
60.00	06000	LABORATORY	2,118	0	86	0	1
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY					
65.00	06500	RESPIRATORY THERAPY	420	0	0	0	9,850
66.00	06600	PHYSICAL THERAPY	2,293	2,031	48	0	14,561
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	988	366	79	0	8,536
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	29	0	0
74.00	07400	RENAL DIALYSIS	0	0	0	0	0
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0
75.01	03950	SLEEP DISORDER	1,991	672	68	0	6,645
75.02	03951	NEW HORIZON OP	757	0	10	0	1,068
75.03	07501	ADULT MENTAL HEALTH	344	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00	09000	CLINIC	0	0	0	0	0
91.00	09100	EMERGENCY	3,187	5,714	311	0	29,333
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	44,424	21,842	1,683	1,548	181,686
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	10	0	0
191.00	19100	RESEARCH	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,856	24	45	0	3,749
193.00	19300	NONPAID WORKERS	0	0	0	0	0
193.01	19301	MARKETING/ PUBLIC RELATIONS	869	0	0	0	2,093
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers					
202.00		Cost to be allocated (per wkst. B, Part I)	2,132,328	96,559	373,057	448,895	296,632
203.00		Unit cost multiplier (wkst. B, Part I)	43.384972	4.415943	214.647296	289.983850	1.581801
204.00		Cost to be allocated (per wkst. B, Part II)	369,229	28,988	22,105	109,964	8,730
205.00		Unit cost multiplier (wkst. B, Part II)	7.512442	1.325711	12.718642	71.036176	0.046553

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151314

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

Worksheet B-1

Date/Time Prepared:
11/28/2012 10:01 am

Cost Center Description		NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
		13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS						
1.00	00100					1.00
2.00	00200					2.00
4.00	00400					4.00
5.00	00500					5.00
7.00	00700					7.00
8.00	00800					8.00
9.00	00900					9.00
10.00	01000					10.00
11.00	01100					11.00
13.00	01300	123				13.00
14.00	01400	0	31,144			14.00
15.00	01500	0	0	100		15.00
16.00	01600	0	0	0	1,644	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	19	0	0	196	30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	20	0	0	295	50.00
54.00	05400	11	0	0	301	54.00
58.00	05800	1	0	0	0	58.00
60.00	06000	8	0	0	0	60.00
61.00	06100					61.00
65.00	06500	4	0	0	0	65.00
66.00	06600	14	0	0	0	66.00
67.00	06700	0	0	0	0	67.00
68.00	06800	0	0	0	0	68.00
69.00	06900	5	0	0	0	69.00
70.00	07000	0	0	0	0	70.00
71.00	07100	0	30,464	0	0	71.00
72.00	07200	0	680	0	0	72.00
73.00	07300	16	0	100	0	73.00
74.00	07400	0	0	0	0	74.00
75.00	07500	0	0	0	0	75.00
75.01	03950	0	0	0	0	75.01
75.02	03951	0	0	0	0	75.02
75.03	07501	0	0	0	0	75.03
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	0	0	0	0	88.00
89.00	08900	0	0	0	0	89.00
90.00	09000	0	0	0	0	90.00
91.00	09100	17	0	0	511	91.00
92.00	09200					92.00
SPECIAL PURPOSE COST CENTERS						
118.00		115	31,144	100	1,303	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	0	0	0	0	190.00
191.00	19100	0	0	0	0	191.00
192.00	19200	8	0	0	341	192.00
193.00	19300	0	0	0	0	193.00
193.01	19301	0	0	0	0	193.01
200.00						200.00
201.00						201.00
202.00		152,236	308,867	501,963	630,041	202.00
203.00		1,237.691057	9.917384	5,019.630000	383.236618	203.00
204.00		7,113	39,329	50,948	45,580	204.00
205.00		57.829268	1.262811	509.480000	27.725061	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151314

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

Worksheet C
Part I
Date/Time Prepared:
11/28/2012 10:01 am

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
				Total Costs	RCE			
				Total Costs	Disallowance			
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,680,658		2,680,658	0	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,324,991		2,324,991	0	0	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	1,749,811		1,749,811	0	0	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	507,422		507,422	0	0	58.00
60.00	06000	LABORATORY	2,214,691		2,214,691	0	0	60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0		0	0	0	61.00
65.00	06500	RESPIRATORY THERAPY	494,790	0	494,790	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,007,393	0	1,007,393	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	483,522		483,522	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	757,403		757,403	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	707,532		707,532	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	890,802		890,802	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
75.01	03950	SLEEP DISORDER	436,654		436,654	0	0	75.01
75.02	03951	NEW HORIZON OP	91,059		91,059	0	0	75.02
75.03	07501	ADULT MENTAL HEALTH	62,097		62,097	0	0	75.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	3,355,829		3,355,829	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	488,845		488,845	0	0	92.00
200.00		Subtotal (see instructions)	18,253,499	0	18,253,499	0	0	200.00
201.00		Less Observation Beds	488,845		488,845	0	0	201.00
202.00		Total (see instructions)	17,764,654	0	17,764,654	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151314

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

Worksheet C
Part I
Date/Time Prepared:
11/28/2012 10:01 am

Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	Cost
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	3,117,982		3,117,982			30.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	685,590	6,342,116	7,027,706	0.330832	0.000000	50.00
54.00 05400 RADIOLOGY - DIAGNOSTIC	327,101	9,393,787	9,720,888	0.180005	0.000000	54.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	52,981	2,365,838	2,418,819	0.209781	0.000000	58.00
60.00 06000 LABORATORY	725,020	6,977,257	7,702,277	0.287537	0.000000	60.00
61.00 06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0	0	0.000000	0.000000	61.00
65.00 06500 RESPIRATORY THERAPY	145,341	654,178	799,519	0.618860	0.000000	65.00
66.00 06600 PHYSICAL THERAPY	412,281	2,560,158	2,972,439	0.338911	0.000000	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00 06900 ELECTROCARDIOLOGY	63,971	1,586,575	1,650,546	0.292947	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	1,392,041	967,421	2,359,462	0.321007	0.000000	71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	907,544	140,081	1,047,625	0.675368	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	835,331	1,560,231	2,395,562	0.371855	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
75.01 03950 SLEEP DISORDER	0	953,136	953,136	0.458123	0.000000	75.01
75.02 03951 NEW HORIZON OP	0	0	0	0.000000	0.000000	75.02
75.03 07501 ADULT MENTAL HEALTH	0	24,546	24,546	2.529822	0.000000	75.03
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0	0			88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			89.00
90.00 09000 CLINIC	0	0	0	0.000000	0.000000	90.00
91.00 09100 EMERGENCY	39,270	5,261,326	5,300,596	0.633104	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	4,134	275,968	280,102	1.745239	0.000000	92.00
200.00 Subtotal (see instructions)	8,708,587	39,062,618	47,771,205			200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	8,708,587	39,062,618	47,771,205			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151314

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

Worksheet C
Part I
Date/Time Prepared:
11/28/2012 10:01 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
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.000000		50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.000000		54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
60.00	06000	LABORATORY	0.000000		60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0.000000		61.00
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
75.01	03950	SLEEP DISORDER	0.000000		75.01
75.02	03951	NEW HORIZON OP	0.000000		75.02
75.03	07501	ADULT MENTAL HEALTH	0.000000		75.03
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC			88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER			89.00
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
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: 151314

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

Worksheet C
Part I
Date/Time Prepared:
11/28/2012 10:01 am

Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Title XIX		Hospital		Total Costs
			Total Costs	RCE	RCE	Total Costs	
			1.00	2.00	3.00	4.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000 ADULTS & PEDIATRICS	2,680,658		2,680,658	0	0	0	30.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	2,324,991		2,324,991	0	0	0	50.00
54.00 05400 RADIOLOGY - DIAGNOSTIC	1,749,811		1,749,811	0	0	0	54.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	507,422		507,422	0	0	0	58.00
60.00 06000 LABORATORY	2,214,691		2,214,691	0	0	0	60.00
61.00 06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0		0	0	0	0	61.00
65.00 06500 RESPIRATORY THERAPY	494,790	0	494,790	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	1,007,393	0	1,007,393	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	483,522		483,522	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0		0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	757,403		757,403	0	0	0	71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	707,532		707,532	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	890,802		890,802	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
75.01 03950 SLEEP DISORDER	436,654		436,654	0	0	0	75.01
75.02 03951 NEW HORIZON OP	91,059		91,059	0	0	0	75.02
75.03 07501 ADULT MENTAL HEALTH	62,097		62,097	0	0	0	75.03
OUTPATIENT SERVICE COST CENTERS							
88.00 08800 RURAL HEALTH CLINIC	0		0	0	0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	0	89.00
90.00 09000 CLINIC	0		0	0	0	0	90.00
91.00 09100 EMERGENCY	3,355,829		3,355,829	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	488,845		488,845	0	0	0	92.00
200.00 Subtotal (see instructions)	18,253,499	0	18,253,499	0	0	0	200.00
201.00 Less Observation Beds	488,845		488,845	0	0	0	201.00
202.00 Total (see instructions)	17,764,654	0	17,764,654	0	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151314

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

Worksheet C
Part I
Date/Time Prepared:
11/28/2012 10:01 am

Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	Cost
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
Title XIX Hospital						
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	3,117,982		3,117,982			30.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	685,590	6,342,116	7,027,706	0.330832	0.000000	50.00
54.00 05400 RADIOLOGY - DIAGNOSTIC	327,101	9,393,787	9,720,888	0.180005	0.000000	54.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	52,981	2,365,838	2,418,819	0.209781	0.000000	58.00
60.00 06000 LABORATORY	725,020	6,977,257	7,702,277	0.287537	0.000000	60.00
61.00 06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0	0	0.000000	0.000000	61.00
65.00 06500 RESPIRATORY THERAPY	145,341	654,178	799,519	0.618860	0.000000	65.00
66.00 06600 PHYSICAL THERAPY	412,281	2,560,158	2,972,439	0.338911	0.000000	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00 06900 ELECTROCARDIOLOGY	63,971	1,586,575	1,650,546	0.292947	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	1,392,041	967,421	2,359,462	0.321007	0.000000	71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	907,544	140,081	1,047,625	0.675368	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	835,331	1,560,231	2,395,562	0.371855	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
75.01 03950 SLEEP DISORDER	0	953,136	953,136	0.458123	0.000000	75.01
75.02 03951 NEW HORIZON OP	0	0	0	0.000000	0.000000	75.02
75.03 07501 ADULT MENTAL HEALTH	0	24,546	24,546	2.529822	0.000000	75.03
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0.000000	0.000000	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	0.000000	89.00
90.00 09000 CLINIC	0	0	0	0.000000	0.000000	90.00
91.00 09100 EMERGENCY	39,270	5,261,326	5,300,596	0.633104	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	4,134	275,968	280,102	1.745239	0.000000	92.00
200.00 Subtotal (see instructions)	8,708,587	39,062,618	47,771,205			200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	8,708,587	39,062,618	47,771,205			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151314

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

Worksheet C
Part I
Date/Time Prepared:
11/28/2012 10:01 am

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.000000		50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.000000		54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
60.00	06000	LABORATORY	0.000000		60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0.000000		61.00
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
75.01	03950	SLEEP DISORDER	0.000000		75.01
75.02	03951	NEW HORIZON OP	0.000000		75.02
75.03	07501	ADULT MENTAL HEALTH	0.000000		75.03
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 151314

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

Worksheet D
Part II
Date/Time Prepared:
11/28/2012 10:01 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	241,705	7,027,706	0.034393	517,313	17,792	50.00
54.00	05400 RADIOLOGY - DIAGNOSTIC	116,799	9,720,888	0.012015	126,500	1,520	54.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	226,820	2,418,819	0.093773	20,158	1,890	58.00
60.00	06000 LABORATORY	98,551	7,702,277	0.012795	356,247	4,558	60.00
61.00	06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY						61.00
65.00	06500 RESPIRATORY THERAPY	21,943	799,519	0.027445	99,251	2,724	65.00
66.00	06600 PHYSICAL THERAPY	67,574	2,972,439	0.022734	91,069	2,070	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	31,984	1,650,546	0.019378	53,420	1,035	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	51,815	2,359,462	0.021961	367,092	8,062	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	21,400	1,047,625	0.020427	239,320	4,889	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	62,876	2,395,562	0.026247	379,194	9,953	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
75.01	03950 SLEEP DISORDER	51,786	953,136	0.054332	0	0	75.01
75.02	03951 NEW HORIZON OP	14,062	0	0.000000	0	0	75.02
75.03	07501 ADULT MENTAL HEALTH	6,965	24,546	0.283753	0	0	75.03
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000 CLINIC	0	0	0.000000	0	0	90.00
91.00	09100 EMERGENCY	170,375	5,300,596	0.032143	2,951	95	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	280,102	0.000000	0	0	92.00
200.00	Total (lines 50-199)	1,184,655	44,653,223		2,252,515	54,588	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151314

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

Worksheet D
Part IV
Date/Time Prepared:
11/28/2012 10:01 am

Cost Center Description	Title XVIII			Hospital		Total Cost (Sum of col 1 through col. 4) 5.00	
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost			
	1.00	2.00	3.00	4.00			
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	0	0	0	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0	0	0	61.00
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
75.01	03950	SLEEP DISORDER	0	0	0	0	75.01
75.02	03951	NEW HORIZON OP	0	0	0	0	75.02
75.03	07501	ADULT MENTAL HEALTH	0	0	0	0	75.03
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151314

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

Worksheet D
Part IV
Date/Time Prepared:
11/28/2012 10:01 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	7,027,706	0.000000	0.000000	517,313	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	9,720,888	0.000000	0.000000	126,500	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	2,418,819	0.000000	0.000000	20,158	58.00
60.00	06000	LABORATORY	0	7,702,277	0.000000	0.000000	356,247	60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0					61.00
65.00	06500	RESPIRATORY THERAPY	0	799,519	0.000000	0.000000	99,251	65.00
66.00	06600	PHYSICAL THERAPY	0	2,972,439	0.000000	0.000000	91,069	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,650,546	0.000000	0.000000	53,420	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,359,462	0.000000	0.000000	367,092	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	1,047,625	0.000000	0.000000	239,320	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,395,562	0.000000	0.000000	379,194	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
75.01	03950	SLEEP DISORDER	0	953,136	0.000000	0.000000	0	75.01
75.02	03951	NEW HORIZON OP	0	0	0.000000	0.000000	0	75.02
75.03	07501	ADULT MENTAL HEALTH	0	24,546	0.000000	0.000000	0	75.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	5,300,596	0.000000	0.000000	2,951	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	280,102	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	44,653,223			2,252,515	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151314

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

Worksheet D
Part IV
Date/Time Prepared:
11/28/2012 10:01 am

Cost Center Description	Title XVIII			Hospital		
	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
	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
54.00 05400 RADIOLOGY - DIAGNOSTIC	0	0	0	0	0	54.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00 06000 LABORATORY	0	0	0	0	0	60.00
61.00 06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0	0	0	0	61.00
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
75.01 03950 SLEEP DISORDER	0	0	0	0	0	75.01
75.02 03951 NEW HORIZON OP	0	0	0	0	0	75.02
75.03 07501 ADULT MENTAL HEALTH	0	0	0	0	0	75.03
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 09000 CLINIC	0	0	0	0	0	90.00
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
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: 151314

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

Worksheet D
Part IV
Date/Time Prepared:
11/28/2012 10:01 am

Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	Title XVIII	Hospital	Cost
		23.00	24.00			
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0		50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	0		54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0		61.00
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
75.01	03950	SLEEP DISORDER	0	0		75.01
75.02	03951	NEW HORIZON OP	0	0		75.02
75.03	07501	ADULT MENTAL HEALTH	0	0		75.03
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Total (lines 50-199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151314	Period: From 07/01/2011 To 06/30/2012	Worksheet D Part V Date/Time Prepared: 11/28/2012 10:01 am
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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	0.330832	0	1,814,068	0	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.180005	0	2,824,853	0	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.209781	0	563,750	0	58.00
60.00	06000	LABORATORY	0.287537	0	2,472,710	0	60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0.000000	0	0	0	61.00
65.00	06500	RESPIRATORY THERAPY	0.618860	0	55,093	0	65.00
66.00	06600	PHYSICAL THERAPY	0.338911	0	681,707	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.292947	0	1,236,188	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.321007	0	541,988	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.675368	0	150,554	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.371855	0	1,025,735	486	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
75.01	03950	SLEEP DISORDER	0.458123	0	0	0	75.01
75.02	03951	NEW HORIZON OP	0.000000	0	0	0	75.02
75.03	07501	ADULT MENTAL HEALTH	2.529822	0	21,517	0	75.03
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000				88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				89.00
90.00	09000	CLINIC	0.000000	0	0	0	90.00
91.00	09100	EMERGENCY	0.633104	0	1,295,940	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.745239	0	127,209	0	92.00
200.00		Subtotal (see instructions)		0	12,811,312	486	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00		Net Charges (line 200 +/- line 201)		0	12,811,312	486	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151314

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

Worksheet D
Part V
Date/Time Prepared:
11/28/2012 10:01 am

Cost Center Description		Title XVIII			Hospital	Cost
		Costs				
		PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)		
		5.00	6.00	7.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	600,152	0	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	508,488	0	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	118,264	0	58.00
60.00	06000	LABORATORY	0	710,996	0	60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0	0	61.00
65.00	06500	RESPIRATORY THERAPY	0	34,095	0	65.00
66.00	06600	PHYSICAL THERAPY	0	231,038	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	362,138	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	173,982	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	101,679	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	381,425	181	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	75.00
75.01	03950	SLEEP DISORDER	0	0	0	75.01
75.02	03951	NEW HORIZON OP	0	0	0	75.02
75.03	07501	ADULT MENTAL HEALTH	0	54,434	0	75.03
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	90.00
91.00	09100	EMERGENCY	0	820,465	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	222,010	0	92.00
200.00		Subtotal (see instructions)	0	4,319,166	181	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	4,319,166	181	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151314

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

Worksheet D
Part V
Date/Time Prepared:
11/28/2012 10:01 am

Component CCN: 152314

Title XVIII Swing Beds - SNF Cost

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	0.330832	0	0	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.180005	0	0	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.209781	0	0	58.00
60.00	06000	LABORATORY	0.287537	0	0	60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0.000000	0	0	61.00
65.00	06500	RESPIRATORY THERAPY	0.618860	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.338911	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.292947	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.321007	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.675368	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.371855	0	0	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
75.01	03950	SLEEP DISORDER	0.458123	0	0	75.01
75.02	03951	NEW HORIZON OP	0.000000	0	0	75.02
75.03	07501	ADULT MENTAL HEALTH	2.529822	0	0	75.03
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000			88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000			89.00
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.633104	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.745239	0	0	92.00
200.00		Subtotal (see instructions)		0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151314

Period: From 07/01/2011

Worksheet D

Component CCN: 152314

To 06/30/2012

Part V

Date/Time Prepared: 11/28/2012 10:01 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
54.00	05400 RADIOLOGY - DIAGNOSTIC	0	0	0		54.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
60.00	06000 LABORATORY	0	0	0		60.00
61.00	06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0	0		61.00
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
75.01	03950 SLEEP DISORDER	0	0	0		75.01
75.02	03951 NEW HORIZON OP	0	0	0		75.02
75.03	07501 ADULT MENTAL HEALTH	0	0	0		75.03
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000 CLINIC	0	0	0		90.00
91.00	09100 EMERGENCY	0	0	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00	Subtotal (see instructions)	0	0	0		200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00	Net Charges (line 200 +/- line 201)	0	0	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 151314	Period: From 07/01/2011 To 06/30/2012	Worksheet D Part I Date/Time Prepared: 11/28/2012 10:01 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)		
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	301,095	57,879	243,216	1,559	156.01	30.00
200.00		Total (lines 30-199)	301,095		243,216	1,559		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 151314

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

Worksheet D
Part I
Date/Time Prepared:
11/28/2012 10:01 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	33	5,148
200.00		Total (lines 30-199)	33	5,148

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 151314

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

Worksheet D
Part II
Date/Time Prepared:
11/28/2012 10:01 am

Cost Center Description		Title XIX			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	241,705	7,027,706	0.034393	168,277	5,788	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	116,799	9,720,888	0.012015	54,463	654	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	226,820	2,418,819	0.093773	0	0	58.00
60.00	06000	LABORATORY	98,551	7,702,277	0.012795	74,480	953	60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY						61.00
65.00	06500	RESPIRATORY THERAPY	21,943	799,519	0.027445	28,118	772	65.00
66.00	06600	PHYSICAL THERAPY	67,574	2,972,439	0.022734	7,612	173	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	31,984	1,650,546	0.019378	4,085	79	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	51,815	2,359,462	0.021961	23,241	510	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	21,400	1,047,625	0.020427	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	62,876	2,395,562	0.026247	63,112	1,657	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
75.01	03950	SLEEP DISORDER	51,786	953,136	0.054332	0	0	75.01
75.02	03951	NEW HORIZON OP	14,062	0	0.000000	0	0	75.02
75.03	07501	ADULT MENTAL HEALTH	6,965	24,546	0.283753	0	0	75.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	170,375	5,300,596	0.032143	36,319	1,167	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	280,102	0.000000	0	0	92.00
200.00		Total (lines 50-199)	1,184,655	44,653,223		459,707	11,753	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151314	Period: From 07/01/2011 To 06/30/2012	Worksheet D Part III Date/Time Prepared: 11/28/2012 10:01 am
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Cost Center Description	Title XIX				Hospital	Cost
	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	0	30.00
200.00 Total (lines 30-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 151314		Period: From 07/01/2011 To 06/30/2012		Worksheet D Part III Date/Time Prepared: 11/28/2012 10:01 am	
Cost Center Description	Total Patient Days	Title XIX		Hospital		Cost	
		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	1,559	0.00	33	0	0 30.00
200.00		Total (lines 30-199)	1,559		33	0	0 200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 151314		Period: From 07/01/2011 To 06/30/2012	Worksheet D Part III Date/Time Prepared: 11/28/2012 10:01 am
Title XIX			Hospital		Cost
Cost Center Description	PSA Adj. Allied Health Cost	PSA Adj. All Other Medical Education Cost			
	12.00	13.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	0	30.00
200.00		Total (lines 30-199)	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151314

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

Worksheet D
Part IV
Date/Time Prepared:
11/28/2012 10:01 am

Cost Center Description	Title XIX				Hospital	Cost	Total Cost (sum of col 1 through col. 4)	
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost				
	1.00	2.00	3.00	4.00	5.00			
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	0	0	0	0	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0	0	0	0	61.00
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
75.01	03950	SLEEP DISORDER	0	0	0	0	0	75.01
75.02	03951	NEW HORIZON OP	0	0	0	0	0	75.02
75.03	07501	ADULT MENTAL HEALTH	0	0	0	0	0	75.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
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
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: 151314

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

Worksheet D
Part IV
Date/Time Prepared:
11/28/2012 10:01 am

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Title XIX		Hospital		Inpatient Program Charges	Cost
			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)			
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	7,027,706	0.000000	0.000000	168,277	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	9,720,888	0.000000	0.000000	54,463	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	2,418,819	0.000000	0.000000	0	58.00
60.00	06000	LABORATORY	0	7,702,277	0.000000	0.000000	74,480	60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0					61.00
65.00	06500	RESPIRATORY THERAPY	0	799,519	0.000000	0.000000	28,118	65.00
66.00	06600	PHYSICAL THERAPY	0	2,972,439	0.000000	0.000000	7,612	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,650,546	0.000000	0.000000	4,085	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,359,462	0.000000	0.000000	23,241	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	1,047,625	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,395,562	0.000000	0.000000	63,112	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
75.01	03950	SLEEP DISORDER	0	953,136	0.000000	0.000000	0	75.01
75.02	03951	NEW HORIZON OP	0	0	0.000000	0.000000	0	75.02
75.03	07501	ADULT MENTAL HEALTH	0	24,546	0.000000	0.000000	0	75.03
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	5,300,596	0.000000	0.000000	36,319	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	280,102	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	44,653,223			459,707	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151314

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

Worksheet D
Part IV
Date/Time Prepared:
11/28/2012 10:01 am

Cost Center Description	Title XIX			Hospital			
	Inpatient Program	Outpatient Program	Outpatient Program	PSA Adj. Non	PSA Adj.		
	Pass-Through Costs (col. 8 x col. 10)	Charges	Pass-Through Costs (col. 9 x col. 12)	Physician Anesthetist Cost	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	50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	0	0	0	54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0	0	0	61.00
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
75.01	03950	SLEEP DISORDER	0	0	0	0	75.01
75.02	03951	NEW HORIZON OP	0	0	0	0	75.02
75.03	07501	ADULT MENTAL HEALTH	0	0	0	0	75.03
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151314

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

Worksheet D
Part IV
Date/Time Prepared:
11/28/2012 10:01 am

Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	Title XIX	Hospital	Cost
		23.00	24.00			
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0		50.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	0		54.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
61.00	06100	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0		61.00
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
75.01	03950	SLEEP DISORDER	0	0		75.01
75.02	03951	NEW HORIZON OP	0	0		75.02
75.03	07501	ADULT MENTAL HEALTH	0	0		75.03
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Total (lines 50-199)	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151314

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

Worksheet D-1

Date/Time Prepared:
11/28/2012 10:01 am

Title XVIII		Hospital	Cost
Cost Center Description			1.00
PART I - ALL PROVIDER COMPONENTS			
INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		1,982 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,559 2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0 3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		1,206 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		187 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)		184 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		24 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)		28 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		683 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)		185 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)		186 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)	2,680,658	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)	3,661	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)	4,271	25.00
26.00	Total swing-bed cost (see instructions)	521,704	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,158,954	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28.00	General inpatient routine service charges (excluding swing-bed charges)	3,450,063	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	3,450,063	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.625772	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)	2,860.75	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)	2,158,954	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)	1,384.83	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	945,839	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)	945,839	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151314

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

Worksheet D-1

Date/Time Prepared:
11/28/2012 10:01 am

Cost Center Description	Title XVIII		Hospital		Program Cost (col. 3 x col. 4)	
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days		
	1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT						43.00
44.00 CORONARY CARE UNIT						44.00
45.00 BURN INTENSIVE CARE UNIT						45.00
46.00 SURGICAL INTENSIVE CARE UNIT						46.00
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description					1.00	
48.00 Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					830,854	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,776,693	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)					256,194	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					257,578	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					513,772	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)					353	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,384.83	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					488,845	89.00

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COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151314

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

Worksheet D-1

Date/Time Prepared:
11/28/2012 10:01 am

Cost Center Description	Cost	Title XVIII		Hospital	Cost	
		Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	0	0	0.000000	0	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: 151314

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

Worksheet D-1

Date/Time Prepared:
11/28/2012 10:01 am

Cost Center Description		Title XIX	Hospital	Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			1,982 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			1,559 2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.			0 3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			1,206 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			187 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)			184 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			24 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)			28 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			33 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)			2,680,658 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)			515,297 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			2,165,361 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)			3,450,063 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			3,450,063 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.627629 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)			2,860.75 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)			2,165,361 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)			1,388.94 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			45,835 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)			45,835 41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151314

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

Worksheet D-1

Date/Time Prepared:
11/28/2012 10:01 am

Cost Center Description	Title XIX					Program Cost (col. 3 x col. 4)
	Total	Total	Average Per	Hospital	Program Days	
	Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)	Program Days	Program Days	
42.00 NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00	42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT						43.00
44.00 CORONARY CARE UNIT						44.00
45.00 BURN INTENSIVE CARE UNIT						45.00
46.00 SURGICAL INTENSIVE CARE UNIT						46.00
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00
48.00 Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					161,993	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					207,828	49.00
PASS THROUGH COST ADJUSTMENTS						
50.00 Pass through costs applicable to Program inpatient routine services (from wkst. D, sum of Parts I and III)					0	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from wkst. D, sum of Parts II and IV)					0	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00 Program discharges					0	54.00
55.00 Target amount per discharge					0.00	55.00
56.00 Target amount (line 54 x line 55)					0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00 Bonus payment (see instructions)					0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00 Relief payment (see instructions)					0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY						
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)						70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00 Program routine service cost (line 9 x line 71)						72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from worksheet B, Part II, column 26, line 45)						75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00 Program capital-related costs (line 9 x line 76)						77.00
78.00 Inpatient routine service cost (line 74 minus line 77)						78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00 Inpatient routine service cost per diem limitation						81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00 Reasonable inpatient routine service costs (see instructions)						83.00
84.00 Program inpatient ancillary services (see instructions)						84.00
85.00 Utilization review - physician compensation (see instructions)						85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00 Total observation bed days (see instructions)					353	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,388.94	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					490,296	89.00

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COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151314

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

Worksheet D-1

Date/Time Prepared:
11/28/2012 10:01 am

Cost Center Description	Cost	Title XIX		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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 151314

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

Worksheet D-3

Date/Time Prepared:
11/28/2012 10:01 am

Cost Center Description		Ratio of Cost To Charges	Hospital 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		585,032		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.330832	517,313	171,144	50.00
54.00	05400 RADIOLOGY - DIAGNOSTIC	0.180005	126,500	22,771	54.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.209781	20,158	4,229	58.00
60.00	06000 LABORATORY	0.287537	356,247	102,434	60.00
61.00	06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0.000000	0	0	61.00
65.00	06500 RESPIRATORY THERAPY	0.618860	99,251	61,422	65.00
66.00	06600 PHYSICAL THERAPY	0.338911	91,069	30,864	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.292947	53,420	15,649	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.321007	367,092	117,839	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.675368	239,320	161,629	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.371855	379,194	141,005	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
75.01	03950 SLEEP DISORDER	0.458123	0	0	75.01
75.02	03951 NEW HORIZON OP	0.000000	0	0	75.02
75.03	07501 ADULT MENTAL HEALTH	2.529822	0	0	75.03
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000 CLINIC	0.000000	0	0	90.00
91.00	09100 EMERGENCY	0.633104	2,951	1,868	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.745239	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		2,252,515	830,854	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		2,252,515		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 151314
Component CCN: 152314

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

Worksheet D-3
Date/Time Prepared:
11/28/2012 10:01 am

Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	Cost
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		264,111		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.330832	0	0	50.00
54.00	05400 RADIOLOGY - DIAGNOSTIC	0.180005	16,209	2,918	54.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.209781	0	0	58.00
60.00	06000 LABORATORY	0.287537	50,625	14,557	60.00
61.00	06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0.000000	0	0	61.00
65.00	06500 RESPIRATORY THERAPY	0.618860	17,972	11,122	65.00
66.00	06600 PHYSICAL THERAPY	0.338911	216,605	73,410	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.292947	6,466	1,894	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.321007	54,896	17,622	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.675368	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.371855	116,212	43,214	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
75.01	03950 SLEEP DISORDER	0.458123	0	0	75.01
75.02	03951 NEW HORIZON OP	0.000000	0	0	75.02
75.03	07501 ADULT MENTAL HEALTH	2.529822	0	0	75.03
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000 CLINIC	0.000000	0	0	90.00
91.00	09100 EMERGENCY	0.633104	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.745239	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		478,985	164,737	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)		478,985		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 151314

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

Worksheet D-3

Date/Time Prepared:
11/28/2012 10:01 am

Cost Center Description	Ratio of Cost To Charges	Hospital		
		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		108,272		30.00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0.330832	168,277	55,671	50.00
54.00 05400 RADIOLOGY - DIAGNOSTIC	0.180005	54,463	9,804	54.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.209781	0	0	58.00
60.00 06000 LABORATORY	0.287537	74,480	21,416	60.00
61.00 06100 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0.000000	0	0	61.00
65.00 06500 RESPIRATORY THERAPY	0.618860	28,118	17,401	65.00
66.00 06600 PHYSICAL THERAPY	0.338911	7,612	2,580	66.00
67.00 06700 OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0.292947	4,085	1,197	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.321007	23,241	7,461	71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.675368	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.371855	63,112	23,469	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
75.01 03950 SLEEP DISORDER	0.458123	0	0	75.01
75.02 03951 NEW HORIZON OP	0.000000	0	0	75.02
75.03 07501 ADULT MENTAL HEALTH	2.529822	0	0	75.03
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC	0.000000	0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	89.00
90.00 09000 CLINIC	0.000000	0	0	90.00
91.00 09100 EMERGENCY	0.633104	36,319	22,994	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.745239	0	0	92.00
200.00 Total (sum of lines 50-94 and 96-98)		459,707	161,993	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)		459,707		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151314	Period: From 07/01/2011 To 06/30/2012	Worksheet E Part B Date/Time Prepared: 11/28/2012 10:01 am
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		4,319,347	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	PPS payments		0	3.00
4.00	Outlier payment (see instructions)		0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from worksheet D, Part IV, column 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		4,319,347	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from worksheet D-4, Part III, line 69, col. 4)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR 413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)		4,362,540	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)		26,518	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		2,064,031	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)		2,271,991	27.00
28.00	Direct graduate medical education payments (from worksheet E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from worksheet E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		2,271,991	30.00
31.00	Primary payer payments		2,264	31.00
32.00	Subtotal (line 30 minus line 31)		2,269,727	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)		472,751	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		472,751	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		472,751	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)		2,742,478	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)		2,742,478	40.00
41.00	Interim payments		2,758,105	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)		-15,627	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: 151314

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

Worksheet E
Part B
Date/Time Prepared:
11/28/2012 10:01 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: 151314

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

Worksheet E-1
Part I
Date/Time Prepared:
11/28/2012 10:01 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		1,535,538		2,884,522	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	
3.49			0		0	3.49	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM	04/10/2012	127,866	04/10/2012	93,786	3.50	
3.51		06/14/2012	8,945	06/14/2012	32,631	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)		-136,811		-126,417	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)		1,398,727		2,758,105	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		218,907		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		15,627	6.02	
7.00	Total Medicare program liability (see instructions)		1,617,634		2,742,478	7.00	
			0				
				Contractor Number	Date (Mo/Day/Yr)		
				1.00	2.00		
8.00	Name of Contractor					8.00	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151314
Component CCN: 152314

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

Worksheet E-1
Part I
Date/Time Prepared:
11/28/2012 10:01 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		575,010			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
3.49			0			0	3.49
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM	04/10/2012	26,517			0	3.50
3.51		06/14/2012	2,348			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)		-28,865			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)		546,145			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		136,460			0	6.01
6.02	SETTLEMENT TO PROGRAM		0			0	6.02
7.00	Total Medicare program liability (see instructions)		682,605			0	7.00
		0		Contractor Number		Date (Mo/Day/Yr)	
				1.00		2.00	
8.00	Name of Contractor						

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 151314	Period: From 07/01/2011 To 06/30/2012	Worksheet E-2
	Component CCN: 152314		Date/Time Prepared: 11/28/2012 10:01 am

		Swing Beds - SNF		Cost
		Part A	Part B	
		1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)	518,910	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)	166,384	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	371	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)	685,294	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	685,294	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)	685,294	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	2,689	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)	682,605	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)	682,605	0	19.00
20.00	Interim payments	546,145	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)	136,460	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: 151314	Period: From 07/01/2011 To 06/30/2012	Worksheet E-3 Part V Date/Time Prepared: 11/28/2012 10:01 am
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		Title XVIII	Hospital	Cost	
				1.00	
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHS)					
1.00	Inpatient services			1,776,693	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)			1,776,693	4.00
5.00	Primary payer payments			0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			1,794,460	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)			1,794,460	19.00
20.00	Deductibles (exclude professional component)			182,848	20.00
21.00	Excess reasonable cost (from line 16)			0	21.00
22.00	Subtotal (line 19 minus line 20)			1,611,612	22.00
23.00	Coinsurance			14,414	23.00
24.00	Subtotal (line 22 minus line 23)			1,597,198	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			20,436	25.00
26.00	Adjusted reimbursable bad debts (see instructions)			20,436	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			20,436	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)			1,617,634	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)			1,617,634	30.00
31.00	Interim payments			1,398,727	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)			218,907	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2			0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 151314

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

Worksheet E-3
Part VII
Date/Time Prepared:
11/28/2012 10:01 am

	Title XIX	Hospital	Cost
			1.00

PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	207,828	1.00
2.00	Medical and other services	0	2.00
3.00	Organ acquisition (certified transplant centers only)	0	3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	207,828	4.00
5.00	Inpatient primary payer payments	0	5.00
6.00	Outpatient primary payer payments	0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	207,828	7.00
COMPUTATION OF LESSER OF COST OR CHARGES			
Reasonable Charges			
8.00	Routine service charges	108,272	8.00
9.00	Ancillary service charges	459,707	9.00
10.00	Organ acquisition charges, net of revenue	0	10.00
11.00	Incentive from target amount computation	0	11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	567,979	12.00
CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	15.00
16.00	Total customary charges (see instructions)	567,979	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	360,151	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	18.00
19.00	Interns and Residents (see instructions)	0	19.00
20.00	Cost of Teaching Physicians (see instructions)	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	207,828	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	22.00
23.00	Outlier payments	0	23.00
24.00	Program capital payments	0	24.00
25.00	Capital exception payments (see instructions)	0	25.00
26.00	Routine and Ancillary service other pass through costs	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	28.00
29.00	Titles V or XIX enter the sum of lines 27 and 21.	207,828	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	207,828	31.00
32.00	Deductibles	0	32.00
33.00	Coinsurance	0	33.00
34.00	Allowable bad debts (see instructions)	0	34.00
35.00	Utilization review	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	207,828	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	37.00
38.00	Subtotal (line 36 ± line 37)	207,828	38.00
39.00	Direct graduate medical education payments (from wkst. E-4)	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	207,828	40.00
41.00	Interim payments	207,828	41.00
42.00	Balance due provider/program (line 40 minus 41)	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2	0	43.00

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

Provider CCN: 151314

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

Worksheet G

Date/Time Prepared:
11/28/2012 10:01 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	491,155	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	6,671,939	0	0	0	4.00
5.00	Other receivable	575,514	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-4,833,038	0	0	0	6.00
7.00	Inventory	274,776	0	0	0	7.00
8.00	Prepaid expenses	674,526	0	0	0	8.00
9.00	Other current assets	560,587	0	0	0	9.00
10.00	Due from other funds	72,622	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	4,488,081	0	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	0	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	795,856	0	0	0	17.00
18.00	Accumulated depreciation	-221,178	0	0	0	18.00
19.00	Fixed equipment	495,809	0	0	0	19.00
20.00	Accumulated depreciation	-57,504	0	0	0	20.00
21.00	Automobiles and trucks	13,500	0	0	0	21.00
22.00	Accumulated depreciation	-1,406	0	0	0	22.00
23.00	Major movable equipment	296,597	0	0	0	23.00
24.00	Accumulated depreciation	-62,435	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)	1,259,239	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	6,499,083	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	6,499,083	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	12,246,403	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	679,372	0	0	0	37.00
38.00	Salaries, wages, and fees payable	541,935	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	448,256	0	0	0	43.00
44.00	Other current liabilities	1,155,047	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2,824,610	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	1,469,624	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	1,469,624	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	4,294,234	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	7,952,169	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	7,952,169	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	12,246,403	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151314

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

Worksheet G-1

Date/Time Prepared:
11/28/2012 10:01 am

	General Fund		Special Purpose Fund		
	1.00	2.00	3.00	4.00	
1.00 Fund balances at beginning of period		7,798,530		0	1.00
2.00 Net income (loss) (from wkst. G-3, line 29)		50,392			2.00
3.00 Total (sum of line 1 and line 2)		7,848,922		0	3.00
4.00 TRANSFERS FROM AFFILIATES	19,434		0		4.00
5.00 DONATIONS	175,357		0		5.00
6.00 GRANT REV	26,283		0		6.00
7.00	0		0		7.00
8.00	0		0		8.00
9.00	0		0		9.00
10.00 Total additions (sum of line 4-9)		221,074		0	10.00
11.00 Subtotal (line 3 plus line 10)		8,069,996		0	11.00
12.00 PENSION RELATED NA ADJ	53,702		0		12.00
13.00 RELEASED OPERATING	15,759		0		13.00
14.00 RELEASED CAPITAL	92,760		0		14.00
15.00	0		0		15.00
16.00	0		0		16.00
17.00	0		0		17.00
18.00 Total deductions (sum of lines 12-17)		162,221		0	18.00
19.00 Fund balance at end of period per balance sheet (line 11 minus line 18)		7,907,775		0	19.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151314

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

Worksheet G-1

Date/Time Prepared:
11/28/2012 10:01 am

	Endowment Fund		Plant Fund		
	5.00	6.00	7.00	8.00	
1.00 Fund balances at beginning of period		0		0	1.00
2.00 Net income (loss) (from wkst. G-3, line 29)					2.00
3.00 Total (sum of line 1 and line 2)		0		0	3.00
4.00 TRANSFERS FROM AFFILIATES	0		0		4.00
5.00 DONATIONS	0		0		5.00
6.00 GRANT REV	0		0		6.00
7.00	0		0		7.00
8.00	0		0		8.00
9.00	0		0		9.00
10.00 Total additions (sum of line 4-9)		0		0	10.00
11.00 Subtotal (line 3 plus line 10)		0		0	11.00
12.00 PENSION RELATED NA ADJ	0		0		12.00
13.00 RELEASED OPERATING	0		0		13.00
14.00 RELEASED CAPITAL	0		0		14.00
15.00	0		0		15.00
16.00	0		0		16.00
17.00	0		0		17.00
18.00 Total deductions (sum of lines 12-17)		0		0	18.00
19.00 Fund balance at end of period per balance sheet (line 11 minus line 18)		0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 151314

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
11/28/2012 10:01 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	3,450,063		3,450,063	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)	3,450,063		3,450,063	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	3,450,063		3,450,063	17.00
18.00	Ancillary services	4,978,487	34,610,724	39,589,211	18.00
19.00	Outpatient services	69,159	5,346,943	5,416,102	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	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)	8,497,709	39,957,667	48,455,376	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per wkst. A, column 3, line 200)		18,394,688		29.00
30.00	BAD DEBT	3,453,315			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		3,453,315		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to wkst. G-3, line 4)		21,848,003		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 151314

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

Worksheet G-3

Date/Time Prepared:
11/28/2012 10:01 am

		1.00	
1.00	Total patient revenues (from wkst. G-2, Part I, column 3, line 28)	48,455,376	1.00
2.00	Less contractual allowances and discounts on patients' accounts	26,797,994	2.00
3.00	Net patient revenues (line 1 minus line 2)	21,657,382	3.00
4.00	Less total operating expenses (from wkst. G-2, Part II, line 43)	21,848,003	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-190,621	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and telegraph service	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	65,936	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	20,614	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	125,742	22.00
23.00	Governmental appropriations	0	23.00
24.00	GRANTS	16,606	24.00
24.01	MISC REVENUE	7,098	24.01
24.02	NET ASSETS RELEASED FROM RESTRICTION	15,759	24.02
24.03	NONOPERATING GAINS/LOSSES	11,435	24.03
24.04	OTHER - PT	20	24.04
24.05		0	24.05
24.06		0	24.06
25.00	Total other income (sum of lines 6-24)	263,210	25.00
26.00	Total (line 5 plus line 25)	72,589	26.00
27.00	NON-CASH FUNDED PENSION CURTAILMENT	22,197	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	22,197	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	50,392	29.00