

**ST. VINCENT SETON SPECIALTY HOSPITAL
LAFAYETTE, IN**

**MEDICARE PROVIDER NO. 15-2021
AND MEDICAID AIM NO. 200413490A**

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

JUNE 30, 2012

ST. VINCENT SETON SPECIALTY HOSPITAL
LAFAYETTE, IN

MEDICARE PROVIDER NO. 15-2021
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Accountants' Disclaimer

Hospital Statements of Reimbursable Costs



Bradley Associates
Healthcare Advisors and CPAs

Board of Directors
St. Vincent Seton Specialty Hospital-Lafayette
Lafayette, IN

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

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

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

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

Bradley Associates

November 26, 2012

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). FORM APPROVED OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 152021	Period: From 07/01/2011 To 06/30/2012	Worksheet S Parts I-III Date/Time Prepared: 11/26/2012 2:34 pm
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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: 11/26/2012 Time: 2:34 pm
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 SETON SPECIALTY HOSP-LAF for the cost reporting period beginning 07/01/2011 and ending 06/30/2012 and to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services identified in this cost report were provided in compliance with such laws and regulations.

Encryption Information

ECR: Date: 11/26/2012 Time: 2:34 pm
 OYHpXA8YynnM0IoucV82hrjXwz45sN0
 a:5tV0lwWtJah6qVd0I68giI17T:::
 hwXl0pgdJk0Mz4j1
 PI: Date: 11/26/2012 Time: 2:34 pm
 8t:LL8fxgsQmkTyKldoqqeoEAG.ji0
 Zc.n50kJ9qcvJV40iPo5mZxvrmXGiw
 qCgsKhtwyt0zoGdc

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

 Title

 Date

	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	74,612	0	0	1.00
2.00	Subprovider - IPF	0	0	0	0	2.00
3.00	Subprovider - IRF	0	0	0	0	3.00
4.00	SUBPROVIDER I	0	0	0	0	4.00
5.00	Swing bed - SNF	0	0	0	0	5.00
6.00	Swing bed - NF	0	0	0	0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0	0	7.00
8.00	NURSING FACILITY	0	0	0	0	8.00
9.00	HOME HEALTH AGENCY I	0	0	0	0	9.00
10.00	RURAL HEALTH CLINIC I	0	0	0	0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0	0	0	0	11.00
12.00	CMHC I	0	0	0	0	12.00
200.00	Total	0	74,612	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: 152021

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

Worksheet S-2
Part I
Date/Time Prepared:
11/20/2012 4:58 pm

		1.00	2.00	3.00	4.00					
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 1501 HARTFORD STREET	PO Box:		Zip Code: 47904		County: TIPPECANOE			1.00	
2.00	City: LAFAYETTE	State: IN							2.00	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)		
								V	XVIII	
									XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
Hospital and Hospital-Based Component Identification:										
3.00	Hospital	ST VINCENT SETON SPECIALTY HOSP-LAF		152021	29140	2	02/07/2003	N	P	O
4.00	Subprovider - IPF									
5.00	Subprovider - IRF									
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF							N	N	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									
16.00	Hospital-Based Health Clinic - FQHC									
17.00	Hospital-Based (CMHC) 1									
18.00	Renal Dialysis									
19.00	Other									
							From:	To:		
							1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)						07/01/2011	06/30/2012		20.00
21.00	Type of Control (see instructions)						1			21.00
Inpatient PPS Information										
22.00	Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.						N		N	
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		24.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.	0	0	0	0	0	0		25.00	
							Urban/Rural S	Date of Geogr		
							1.00	2.00		
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter (1) for urban or (2) for rural.						1			26.00
27.00	For the Standard Geographic Classification (not wage), what is your status at the end of the cost reporting period. Enter (1) for urban or (2) for rural. If applicable, enter the effective date of the geographic reclassification in column 2.						1			27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.						0			35.00
							Beginning:	Ending:		
							1.00	2.00		
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.									36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.						0			37.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 152021	Period: From 07/01/2011 To 06/30/2012	Worksheet S-2 Part I Date/Time Prepared: 11/20/2012 4:58 pm		
		Beginning: 1.00	Ending: 2.00			
		V 1.00	XVIII 2.00	XIX 3.00		
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.					38.00
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N		45.00
46.00	Is this facility eligible for the special exceptions payment pursuant to 42 CFR Section §412.348(g)? If yes, complete worksheet L, Part III and L-1, Parts I through III	N	N	N		46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N		47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N				56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete worksheet E-4. If column 2 is "N", complete worksheet D, Part III & IV and D-2, Part II, if applicable.					57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete worksheet D-5.					58.00
59.00	Are costs claimed on line 100 of worksheet A? If yes, complete worksheet D-2, Part I.	N				59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N				60.00
		Y/N 1.00	IME Average 2.00	Direct GME Average 3.00		
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00		61.00
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)		0.00			62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)		0.00			62.01
Teaching Hospitals that Claim Residents in Non-Provider Settings						
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)	N				63.00
		Unweighted FTEs Nonprovider Site 1.00	Unweighted FTEs in Hospital 2.00	Ratio (col. 1/ (col. 1 + col. 2)) 3.00		
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. If line 63 is yes or your facility trained residents in the base year period, enter in column 1, from your cost reporting period that begins on or after July 1, 2009, and before June 30, 2010 the number of unweighted nonprimary care FTE residents attributable to rotations that occurred in all nonprovider settings. Enter in column 2 the number of unweighted nonprimary care FTE residents that trained in your hospital. Include unweighted OB/GYN, dental and podiatry FTEs on this line. Enter in column 3, the ratio of column 1 divided by the sum of columns 1 and 2.		0.00	0.00	0.000000	64.00
		Program Name 1.00	Program Code 2.00	Unweighted FTEs Nonprovider Site 3.00	Unweighted FTEs in Hospital 4.00	Ratio (col. 3/ (col. 3 + col. 4)) 5.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 152021

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

Worksheet S-2
Part I
Date/Time Prepared:
11/20/2012 4:58 pm

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	If line 63 is yes or your facility trained residents in the base year period, enter from your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010, the number of unweighted primary care FTE residents for each primary care specialty program in which you train residents. Use subscripted lines 65.01 through 65.50 for each additional primary care program. Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations that occurred in nonprovider settings for each applicable program. Enter in column 4, the number of unweighted primary care FTE residents in your hospital for each applicable program. Enter in column 5 the ratio of column 3 divided by the sum of columns 3 and 4. (see instructions)			0.00	0.00	0.000000	65.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
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: 152021	Period: From 07/01/2011 To 06/30/2012	Worksheet S-2 Part I Date/Time Prepared: 11/20/2012 4:58 pm		
		1.00	2.00	3.00		
Inpatient Psychiatric Facility PPS						
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N				70.00
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period 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		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.)			Y		80.00
TEFRA Providers						
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			N		86.00
		V	XIX			
		1.00	2.00			
Title V or XIX Inpatient Services						
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N		Y		90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N		Y		91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N		92.00
93.00	Does this facility operate an ICFV/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N		N		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N		N		94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00		95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N		96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00		97.00
Rural Providers						
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	N				105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)					106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)					107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N				108.00
		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					109.00
		1.00	2.00	3.00		
Miscellaneous Cost Reporting Information						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.	N		0		115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 152021	Period: From 07/01/2011 To 06/30/2012	Worksheet S-2 Part I Date/Time Prepared: 11/20/2012 4:58 pm	
		1.00	2.00	3.00	
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2			118.00
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	Enter the total amount of malpractice premiums paid in column 1, enter the total amount of paid losses in column 2, and enter the total amount of self insurance paid in column 3.	14,026	0	0	118.01
		1.00	2.00		
118.02	Indicate if malpractice premiums and paid losses are reported in other than the Administrative and General cost center. If yes, provide a supporting schedule and list the amounts applicable to each cost center.	N			118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	If this is an SCH (or EACH), regardless of bed size, or is rural hospital with 100 or fewer beds that qualifies for the outpatient hold harmless provision in accordance with ACA, section 3121, as amended by the Medicare and Medicaid Extenders Act (MMEA) of 2010, section 108; the Temporary Payroll Tax Cut Continuation Act of 2011, section 308; and the Middle Class Tax Relief and Job Creation Act of 2012, section 3002, enter "Y" for yes or "N" for no in column 1 or column 2, respectively. Note that for SCHs (and EACHs) the outpatient hold harmless provision is effective for services rendered from January 1, 2010 through February 29, 2012 regardless of bed size and from March 1, 2012 through December 31, 2012 to all SCHs (and EACHs) with 100 or fewer beds. These responses impact the TOPs calculation on worksheet E, Part B, line 8.	N	N		120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N			121.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	15H046		140.00
		1.00	2.00	3.00	
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.					
141.00	Name: ST. VINCENT HEALTH	Contractor's Name: WPS		Contractor's Number: 08101	141.00
142.00	Street: 10330 N. MERIDIAN ST.	PO Box:			142.00
143.00	City: INDIANAPOLIS	State: IN		Zip Code: 46290	143.00
		1.00			
144.00	Are provider based physicians' costs included in worksheet A?	N			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.	Y			145.00
		1.00	2.00		
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N			146.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N			147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N			148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N			149.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 152021	Period: From 07/01/2011 To 06/30/2012	Worksheet S-2 Part I Date/Time Prepared: 11/20/2012 4:58 pm
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	Part A	Part B	Title V	Title XIX	
	1.00	2.00	3.00	4.00	
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00 Hospital	N	N	N	N	155.00
156.00 Subprovider - IPF	N	N	N	N	156.00
157.00 Subprovider - IRF	N	N	N	N	157.00
158.00 SUBPROVIDER					158.00
159.00 SNF	N	N	N	N	159.00
160.00 HOME HEALTH AGENCY	N	N	N	N	160.00
161.00 CMHC		N	N	N	161.00

					1.00
--	--	--	--	--	------

Multicampus						
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.				N	165.00

	Name	County	State	Zip Code	CBSA	FTE/Campus	
	0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5					0.00	166.00

							1.00
--	--	--	--	--	--	--	------

Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.					N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						0168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)					0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 152021	Period: From 07/01/2011 To 06/30/2012	Worksheet S-2 Part II Date/Time Prepared: 11/20/2012 4:58 pm
		Y/N	Date	
		1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N	Date	V/I
		1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N		3.00
		Y/N	Type	Date
		1.00	2.00	3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
		Y/N	Legal Oper.	
		1.00	2.00	
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N		9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N	
			1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N	14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N	15.00
		Part A		
		Description	Y/N	Date
		0	1.00	2.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	10/10/2012	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		20.00

		Part A		
Description		Y/N	Date	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	2.00	21.00
				1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)				
Capital Related Cost				
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N		27.00
Interest Expense				
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	N		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N		31.00
Purchased Services				
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N		33.00
Provider-Based Physicians				
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	N		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	N		35.00
		Y/N	Date	
		1.00	2.00	
Home Office Costs				
36.00	Were home office costs claimed on the cost report?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00
		1.00	2.00	
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	GARY	MARKER	41.00
42.00	Enter the employer/company name of the cost report preparer.	ST. VINCENT HEALTH		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-583-3232	GAMARKER@STVINCENT.ORG	43.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 152021

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

Worksheet S-3
Part I
Date/Time Prepared:
11/20/2012 4:58 pm

Cost Center Description		Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	
		1.00	2.00	3.00	4.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	29	10,614	0.00	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)		29	10,614	0.00	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)		29	10,614	0.00	14.00
15.00	CAH visits					15.00
16.00	SUBPROVIDER - IPF					16.00
17.00	SUBPROVIDER - IRF					17.00
18.00	SUBPROVIDER					18.00
19.00	SKILLED NURSING FACILITY					19.00
20.00	NURSING FACILITY					20.00
21.00	OTHER LONG TERM CARE					21.00
22.00	HOME HEALTH AGENCY					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)					23.00
24.00	HOSPICE					24.00
25.00	CMHC - CMHC					25.00
26.00	RURAL HEALTH CLINIC					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER					26.25
27.00	Total (sum of lines 14-26)		29			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: 152021

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

Worksheet S-3
Part I
Date/Time Prepared:
11/20/2012 4:58 pm

Cost Center Description	I/P Days / O/P Visits / Trips					
	Title V	Title XVIII	Title XIX	Total All Patients		
	5.00	6.00	7.00	8.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	0	4,272	277	5,983		1.00
2.00 HMO		508	0			2.00
3.00 HMO IPF		0	0			3.00
4.00 HMO IRF		0	0			4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0	0		5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0	0	0	0		6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	0	4,272	277	5,983		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	4,272	277	5,983		14.00
15.00 CAH visits	0	0	0	0		15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)						27.00
28.00 Observation Bed Days	0		0	0		28.00
29.00 Ambulance Trips		0				29.00
30.00 Employee discount days (see instruction)				0		30.00
31.00 Employee discount days - IRF				0		31.00
32.00 Labor & delivery days (see instructions)			0	0		32.00
33.00 LTCH non-covered days		0				33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 152021

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

Worksheet S-3
Part I
Date/Time Prepared:
11/20/2012 4:58 pm

Cost Center Description	Full Time Equivalents			Discharges		
	Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title v	Title XVIII	
	9.00	10.00	11.00	12.00	13.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)				0	170	1.00
2.00 HMO					17	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	84.19	0.00	0	170	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)	0.00	84.19	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: 152021

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

Worksheet 5-3
Part I
Date/Time Prepared:
11/20/2012 4:58 pm

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)	6	243		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)	6	243		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

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 152021

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

Worksheet A

Date/Time Prepared:
11/20/2012 4:58 pm

Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)		
	1.00	2.00	3.00	4.00	5.00		
GENERAL SERVICE COST CENTERS							
1.00 00100	CAP REL COSTS-BLDG & FIXT		540,216	540,216	-17	540,199	1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		379,972	379,972	0	379,972	2.00
3.00 00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00 00400	EMPLOYEE BENEFITS	74,055	1,451,107	1,525,162	0	1,525,162	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	851,590	784,368	1,635,958	17	1,635,975	5.00
6.00 00601	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00 00700	OPERATION OF PLANT	53,815	67,527	121,342	0	121,342	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00 00900	HOUSEKEEPING	0	41,950	41,950	0	41,950	9.00
10.00 01000	DIETARY	0	113,918	113,918	0	113,918	10.00
11.00 01100	CAFETERIA	0	0	0	0	0	11.00
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00 01300	NURSING ADMINISTRATION	367,435	7,802	375,237	0	375,237	13.00
15.00 01500	PHARMACY	377,126	574,840	951,966	0	951,966	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	17,328	18,472	35,800	0	35,800	16.00
17.00 01700	SOCIAL SERVICE	52,779	136	52,915	0	52,915	17.00
18.00 01850	PASTORAL CARE	48,684	773	49,457	0	49,457	18.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00 02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00 02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	2,574,235	448,347	3,022,582	-118,780	2,903,802	30.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	1,721	-7,342	-5,621	118,780	113,159	50.00
51.00 05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	469	251,122	251,591	0	251,591	54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00 05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00 05700	CT SCAN	0	46,502	46,502	0	46,502	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000	LABORATORY	0	244,753	244,753	0	244,753	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0	60.01
61.00 06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	37,930	37,930	0	37,930	63.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	741,406	452,425	1,193,831	0	1,193,831	65.00
66.00 06600	PHYSICAL THERAPY	25,745	144,461	170,206	0	170,206	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	46,923	46,923	0	46,923	67.00
68.00 06800	SPEECH PATHOLOGY	0	90,052	90,052	0	90,052	68.00
69.00 06900	ELECTROCARDIOLOGY	0	68,551	68,551	0	68,551	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	5,928	5,928	0	5,928	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	0	165,329	165,329	0	165,329	74.00
75.00 07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
OTHER REIMBURSABLE COST CENTERS							
100.00 10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	5,186,388	5,976,062	11,162,450	0	11,162,450	118.00
NONREIMBURSABLE COST CENTERS							
193.00 19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01 07952	MARKETING	0	0	0	0	0	194.01
200.00	TOTAL (SUM OF LINES 118-199)	5,186,388	5,976,062	11,162,450	0	11,162,450	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 152021

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

Worksheet A
Date/Time Prepared:
11/20/2012 4:58 pm

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation		
		6.00	7.00		
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	139,700	679,899	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	379,972	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS	37,890	1,563,052	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	9,275	1,645,250	5.00
6.00	00601	MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700	OPERATION OF PLANT	-325	121,017	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	8.00
9.00	00900	HOUSEKEEPING	0	41,950	9.00
10.00	01000	DIETARY	-46	113,872	10.00
11.00	01100	CAFETERIA	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	-1,187	374,050	13.00
15.00	01500	PHARMACY	0	951,966	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-1,706	34,094	16.00
17.00	01700	SOCIAL SERVICE	-70	52,845	17.00
18.00	01850	PASTORAL CARE	0	49,457	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-2,993	2,900,809	30.00
ANCELLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	113,159	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	251,591	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	46,502	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	244,753	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	37,930	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,193,831	65.00
66.00	06600	PHYSICAL THERAPY	0	170,206	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	46,923	67.00
68.00	06800	SPEECH PATHOLOGY	0	90,052	68.00
69.00	06900	ELECTROCARDIOLOGY	0	68,551	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	5,928	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	165,329	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	75.00
OTHER REIMBURSABLE COST CENTERS					
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	100.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	180,538	11,342,988	118.00
NONREIMBURSABLE COST CENTERS					
193.00	19300	NONPAID WORKERS	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.00
194.01	07952	MARKETING	157,899	157,899	194.01
200.00		TOTAL (SUM OF LINES 118-199)	338,437	11,500,887	200.00

Provider CCN: 152021

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

Worksheet A-6

Date/Time Prepared:
11/20/2012 4:58 pm

Increases					
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
A - INTEREST					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	17	1.00
	TOTALS		0	17	
B - OR EXPENSES					
1.00	OPERATING ROOM	50.00	0	118,780	1.00
	TOTALS		0	118,780	
500.00	Grand Total: Increases		0	118,797	500.00

Provider CCN: 152021

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

Date/Time Prepared:
11/20/2012 4:58 pm

Decreases						wkst. A-7 Ref.	
Cost Center	Line #	Salary	Other				
6.00	7.00	8.00	9.00	10.00			
A - INTEREST							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	17	11		1.00
	TOTALS		0	17			
B - DR EXPENSES							
1.00	ADULTS & PEDIATRICS	30.00	0	118,780	0		1.00
	TOTALS		0	118,780			
500.00	Grand Total: Decreases		0	118,797			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 152021

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
11/20/2012 4:58 pm

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	3.00
4.00	Building Improvements	845,098	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	5.00
6.00	Movable Equipment	1,068,622	33,255	0	33,255	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	1,913,720	33,255	0	33,255	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	1,913,720	33,255	0	33,255	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	121,112	416,815	134	2,130	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	95,075	284,897	0	0	2.00
3.00	Total (sum of lines 1-2)	216,187	701,712	134	2,130	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	845,098	0	845,098	0.434057	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,101,877	0	1,101,877	0.565943	2.00
3.00	Total (sum of lines 1-2)	1,946,975	0	1,946,975	1.000000	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 152021

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
11/20/2012 4:58 pm

		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	845,098	0		4.00		
5.00	Fixed Equipment	0	0		5.00		
6.00	Movable Equipment	1,101,877	0		6.00		
7.00	HIT designated Assets	0	0		7.00		
8.00	Subtotal (sum of lines 1-7)	1,946,975	0		8.00		
9.00	Reconciling Items	0	0		9.00		
10.00	Total (line 8 minus line 9)	1,946,975	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	540,216		1.00		
2.00	CAP REL COSTS-MVBLE EQUIP	0	379,972		2.00		
3.00	Total (sum of lines 1-2)	0	920,188		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	260,825	416,815	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	95,075	284,897	2.00
3.00	Total (sum of lines 1-2)	0	0	0	355,900	701,712	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 152021

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
11/20/2012 4:58 pm

Cost Center Description	SUMMARY OF CAPITAL						
	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)		
	11.00	12.00	13.00	14.00	15.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	104	2,130	25	0	679,899	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	379,972	2.00
3.00	Total (sum of lines 1-2)	104	2,130	25	0	1,059,871	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
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-107	CAP REL COSTS-BLDG & FIXT		1.00 1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP		2.00 2.00
3.00 Investment income - other (chapter 2)	B	-15	ADMINISTRATIVE & GENERAL		5.00 3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0			0.00 4.00
5.00 Refunds and rebates of expenses (chapter 8)		0			0.00 5.00
6.00 Rental of provider space by suppliers (chapter 8)		0			0.00 6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0			0.00 7.00
8.00 Television and radio service (chapter 21)		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	0			0.00 10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0			0.00 11.00
12.00 Related organization transactions (chapter 10)	A-8-1	422,769			12.00 12.00
13.00 Laundry and linen service		0			0.00 13.00
14.00 Cafeteria-employees and guests		0			0.00 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	-1,706	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	NONPHYSICIAN ANESTHETISTS		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 OTHER REV - CDM MAINTENANCE	B	-600	OPERATION OF PLANT		7.00 33.00
33.01 OTHER REV - PATIENT FOOD SERVICES	B	-46	DIETARY		10.00 33.01
33.02 DEVELOPMENTAL CONSULTING FEES	A	-4,298	ADMINISTRATIVE & GENERAL		5.00 33.02
33.03 LOBBYING - NALTH	A	-234	ADMINISTRATIVE & GENERAL		5.00 33.03
33.04 LOBBYING - OTHER	A	-486	ADMINISTRATIVE & GENERAL		5.00 33.04
33.05 CHARITY/DONATIONS	A	-70	SOCIAL SERVICE		17.00 33.05
33.06 CHARITY/DONATIONS	A	-2,895	ADMINISTRATIVE & GENERAL		5.00 33.06
33.07 CHARITY/DONATIONS	A	-86	ADMINISTRATIVE & GENERAL		5.00 33.07
33.08 CHARITY/DONATIONS	A	-1,163	NURSING ADMINISTRATION		13.00 33.08
33.09 LOSS ON SALE OF ASSETS	A	-2,993	ADULTS & PEDIATRICS		30.00 33.09
33.10 NON-REIMBURSABLE ALCOHOL	A	-15	ADMINISTRATIVE & GENERAL		5.00 33.10
33.11 NON-REIMBURSABLE ALCOHOL	A	-24	NURSING ADMINISTRATION		13.00 33.11
33.12 INCENTIVE PAYROLL ADJUSTMENT	A	-64,626	ADMINISTRATIVE & GENERAL		5.00 33.12
33.13 INCENTIVE PAYROLL ADJUSTMENT	A	-4,968	EMPLOYEE BENEFITS		4.00 33.13
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200.)		338,437			50.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 152021

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

Worksheet A-8

Date/Time Prepared:
11/20/2012 4:58 pm

Cost Center Description	5.00	wkst. A-7 Ref.	
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		9	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	2.00
3.00 Investment income - other (chapter 2)		0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0	4.00
5.00 Refunds and rebates of expenses (chapter 8)		0	5.00
6.00 Rental of provider space by suppliers (chapter 8)		0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0	7.00
8.00 Television and radio service (chapter 21)		0	8.00
9.00 Parking lot (chapter 21)		0	9.00
10.00 Provider-based physician adjustment		0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0	11.00
12.00 Related organization transactions (chapter 10)		0	12.00
13.00 Laundry and linen service		0	13.00
14.00 Cafeteria-employees and guests		0	14.00
15.00 Rental of quarters to employee and others		0	15.00
16.00 Sale of medical and surgical supplies to other than patients		0	16.00
17.00 Sale of drugs to other than patients		0	17.00
18.00 Sale of medical records and abstracts		0	18.00
19.00 Nursing school (tuition, fees, books, etc.)		0	19.00
20.00 Vending machines		0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)			23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)			24.00
25.00 Utilization review - physicians' compensation (chapter 21)			25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT		0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP		0	27.00
28.00 Non-physician Anesthetist		0	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 OTHER REV - CDM MAINTENANCE		0	33.00
33.01 OTHER REV - PATIENT FOOD SERVICES		0	33.01
33.02 DEVELOPMENTAL CONSULTING FEES		0	33.02
33.03 LOBBYING - NALTH		0	33.03
33.04 LOBBYING - OTHER		0	33.04
33.05 CHARITY/DONATIONS		0	33.05
33.06 CHARITY/DONATIONS		0	33.06
33.07 CHARITY/DONATIONS		0	33.07
33.08 CHARITY/DONATIONS		0	33.08
33.09 LOSS ON SALE OF ASSETS		0	33.09
33.10 NON-REIMBURSABLE ALCOHOL		0	33.10
33.11 NON-REIMBURSABLE ALCOHOL		0	33.11
33.12 INCENTIVE PAYROLL ADJUSTMENT		0	33.12
33.13 INCENTIVE PAYROLL ADJUSTMENT		0	33.13
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: 152021

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

Worksheet A-8-1

Date/Time Prepared: 11/20/2012 4:58 pm

		Line No.	Cost Center	Expense Items	
		1.00	2.00	3.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00		1.00	CAP REL COSTS-BLDG & FIXT	ST. JOSEPH BLDG RENT	1.00
2.00		4.00	EMPLOYEE BENEFITS	EMPLOYEE BENEFITS	2.00
3.00		4.00	EMPLOYEE BENEFITS	EMPLOYEE BENEFITS - CHARGEBACK	3.00
4.00		5.00	ADMINISTRATIVE & GENERAL	ADMIN - CHARGEBACK	4.00
4.01		7.00	OPERATION OF PLANT	ENGINEERING SVCS - CHARGEBACK	4.01
4.02		10.00	DIETARY	DIETARY - CHARGEBACK	4.02
4.03		13.00	NURSING ADMINISTRATION	NURSING ADMIN - CHARGEBACK	4.03
4.04		15.00	PHARMACY	PHARMACY - CHARGEBACK	4.04
4.05		16.00	MEDICAL RECORDS & LIBRARY	MEDICAL RECORDS - CHARGEBACK	4.05
4.06		18.00	PASTORAL CARE	PASTORAL CARE - CHARGEBACK	4.06
4.07		30.00	ADULTS & PEDIATRICS	ADULT & PEDIATRICS - CHARGEBACK	4.07
4.08		50.00	OPERATING ROOM	OPERATING ROOM - CHARGEBACK	4.08
4.09		54.00	RADIOLOGY-DIAGNOSTIC	RADIOLOGY - CHARGEBACK	4.09
4.10		57.00	CT SCAN	CT SCAN - CHARGEBACK	4.10
4.11		60.00	LABORATORY	LAB - CHARGEBACK	4.11
4.12		63.00	BLOOD STORING, PROCESSING & TRANS.	BLOOD BANK - CHARGEBACK	4.12
4.13		65.00	RESPIRATORY THERAPY	RT - CHARGEBACK	4.13
4.14		66.00	PHYSICAL THERAPY	PT - CHARGEBACK	4.14
4.15		68.00	SPEECH PATHOLOGY	ST - CHARGEBACK	4.15
4.16		69.00	ELECTROCARDIOLOGY	EKG - CHARGEBACK	4.16
4.17		70.00	ELECTROENCEPHALOGRAPHY	EEG - CHARGEBACK	4.17
4.18		4.00	EMPLOYEE BENEFITS	ASCENSION BENEFITS	4.18
4.19		1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE	4.19
4.20		194.01	MARKETING	HOME OFFICE	4.20
4.21		5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	4.21
4.22		1.00	CAP REL COSTS-BLDG & FIXT	ASCENSION INTEREST	4.22
4.23		5.00	ADMINISTRATIVE & GENERAL	ASCENSION INTEREST	4.23
4.24		7.00	OPERATION OF PLANT	HOME OFFICE COSTS - TRIMEDIX	4.24
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to worksheet A-8, column 2, line 12.				5.00

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

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

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

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

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

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS
 Provider CCN: 152021
 Period: From 07/01/2011 To 06/30/2012
 Worksheet A-8-1
 Date/Time Prepared: 11/20/2012 4:58 pm

	Amount of Allowable Cost	Amount Included in Wks. A, column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	4.00	5.00	6.00	7.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	416,815	416,815	0	10	1.00
2.00	810,283	619,023	191,260	0	2.00
3.00	33,630	33,630	0	0	3.00
4.00	96,362	96,362	0	0	4.00
4.01	601	601	0	0	4.01
4.02	112,646	112,646	0	0	4.02
4.03	827	827	0	0	4.03
4.04	28,461	28,461	0	0	4.04
4.05	35,501	35,501	0	0	4.05
4.06	48,684	48,684	0	0	4.06
4.07	82,260	82,260	0	0	4.07
4.08	-7,906	-7,906	0	0	4.08
4.09	251,122	251,122	0	0	4.09
4.10	46,502	46,502	0	0	4.10
4.11	88,419	88,419	0	0	4.11
4.12	37,930	37,930	0	0	4.12
4.13	72,916	72,916	0	0	4.13
4.14	144,398	144,398	0	0	4.14
4.15	90,052	90,052	0	0	4.15
4.16	68,551	68,551	0	0	4.16
4.17	5,928	5,928	0	0	4.17
4.18	0	148,402	-148,402	0	4.18
4.19	139,820	0	139,820	9	4.19
4.20	157,899	0	157,899	0	4.20
4.21	835,160	753,228	81,932	0	4.21
4.22	107	120	-13	11	4.22
4.23	15	17	-2	0	4.23
4.24	2,775	2,500	275	0	4.24
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to worksheet A-8, column 2, line 12.	3,599,758	3,176,989	422,769	5.00

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

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

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

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

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

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

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

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

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 152021

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

Worksheet B
Part I
Date/Time Prepared:
11/20/2012 4:58 pm

Cost Center Description	Net Expenses for Cost Allocation (from wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	679,899	679,899			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	379,972		379,972		2.00
4.00 00400	EMPLOYEE BENEFITS	1,563,052	0	0	1,563,052	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	1,645,250	106,326	59,422	260,366	2,071,364
6.00 00601	MAINTENANCE & REPAIRS	0	0	0	0	0
7.00 00700	OPERATION OF PLANT	121,017	9,109	5,091	16,453	151,670
8.00 00800	LAUNDRY & LINEN SERVICE	0	15,013	8,390	0	23,403
9.00 00900	HOUSEKEEPING	41,950	4,498	2,514	0	48,962
10.00 01000	DIETARY	113,872	18,049	10,087	0	142,008
11.00 01100	CAFETERIA	0	0	0	0	0
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00 01300	NURSING ADMINISTRATION	374,050	36,941	20,645	112,340	543,976
15.00 01500	PHARMACY	951,966	28,845	16,120	115,303	1,112,234
16.00 01600	MEDICAL RECORDS & LIBRARY	34,094	8,322	4,651	5,298	52,365
17.00 01700	SOCIAL SERVICE	52,845	10,964	6,128	16,137	86,074
18.00 01850	PASTORAL CARE	49,457	0	0	14,885	64,342
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
20.00 02000	NURSING SCHOOL	0	0	0	0	0
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0
23.00 02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	2,900,809	425,528	237,811	787,052	4,351,200
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	113,159	0	0	526	113,685
51.00 05100	RECOVERY ROOM	0	0	0	0	0
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0
53.00 05300	ANESTHESIOLOGY	0	0	0	0	0
54.00 05400	RADIOLOGY-DIAGNOSTIC	251,591	0	0	143	251,734
55.00 05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0
56.00 05600	RADIOISOTOPE	0	0	0	0	0
57.00 05700	CT SCAN	46,502	0	0	0	46,502
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00 06000	LABORATORY	244,753	7,984	4,462	0	257,199
60.01 06001	BLOOD LABORATORY	0	0	0	0	0
61.00 06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	37,930	0	0	0	37,930
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00 06500	RESPIRATORY THERAPY	1,193,831	6,803	3,802	226,678	1,431,114
66.00 06600	PHYSICAL THERAPY	170,206	618	346	7,871	179,041
67.00 06700	OCCUPATIONAL THERAPY	46,923	562	314	0	47,799
68.00 06800	SPEECH PATHOLOGY	90,052	337	189	0	90,578
69.00 06900	ELECTROCARDIOLOGY	68,551	0	0	0	68,551
70.00 07000	ELECTROENCEPHALOGRAPHY	5,928	0	0	0	5,928
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
74.00 07400	RENAL DIALYSIS	165,329	0	0	0	165,329
75.00 07500	ASC (NON-DISTINCT PART)	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS						
100.00 10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	11,342,988	679,899	379,972	1,563,052	11,342,988
NONREIMBURSABLE COST CENTERS						
193.00 19300	NONPAID WORKERS	0	0	0	0	0
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
194.01 07952	MARKETING	157,899	0	0	0	157,899
200.00	Cross Foot Adjustments					0
201.00	Negative Cost Centers					0
202.00	TOTAL (sum lines 118-201)	11,500,887	679,899	379,972	1,563,052	11,500,887

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 152021	Period: From 07/01/2011 To 06/30/2012	Worksheet B Part I Date/Time Prepared: 11/20/2012 4:58 pm				
Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING			
	5.00	6.00	7.00	8.00	9.00			
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00		
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00		
4.00	00400	EMPLOYEE BENEFITS				4.00		
5.00	00500	ADMINISTRATIVE & GENERAL	2,071,364			5.00		
6.00	00601	MAINTENANCE & REPAIRS	0	0		6.00		
7.00	00700	OPERATION OF PLANT	33,317	0	184,987	7.00		
8.00	00800	LAUNDRY & LINEN SERVICE	5,141	0	4,920	33,464	8.00	
9.00	00900	HOUSEKEEPING	10,755	0	1,474	0	61,191	9.00
10.00	01000	DIETARY	31,195	0	5,915	0	2,027	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	119,494	0	12,106	0	4,148	13.00
15.00	01500	PHARMACY	244,322	0	9,453	0	3,239	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	11,503	0	2,727	0	934	16.00
17.00	01700	SOCIAL SERVICE	18,908	0	3,593	0	1,231	17.00
18.00	01850	PASTORAL CARE	14,134	0	0	0	0	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	955,820	0	139,454	33,464	47,781	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	24,973	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	55,298	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	10,215	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	56,498	0	2,617	0	897	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	8,332	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	314,370	0	2,230	0	764	65.00
66.00	06600	PHYSICAL THERAPY	39,330	0	203	0	69	66.00
67.00	06700	OCCUPATIONAL THERAPY	10,500	0	184	0	63	67.00
68.00	06800	SPEECH PATHOLOGY	19,897	0	111	0	38	68.00
69.00	06900	ELECTROCARDIOLOGY	15,058	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,302	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	36,317	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
OTHER REIMBURSABLE COST CENTERS								
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,036,679	0	184,987	33,464	61,191	118.00
NONREIMBURSABLE COST CENTERS								
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07952	MARKETING	34,685	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	2,071,364	0	184,987	33,464	61,191	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 152021

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

Worksheet B
Part I
Date/Time Prepared:
11/20/2012 4:58 pm

Cost Center Description		DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	PHARMACY	
		10.00	11.00	12.00	13.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00601						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	181,145					10.00
11.00	01100	0	0				11.00
12.00	01200	0	0	0			12.00
13.00	01300	0	0	0	679,724		13.00
15.00	01500	0	0	0	0	1,369,248	15.00
16.00	01600	0	0	0	0	0	16.00
17.00	01700	0	0	0	0	0	17.00
18.00	01850	0	0	0	0	0	18.00
19.00	01900	0	0	0	0	0	19.00
20.00	02000	0	0	0	0	0	20.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
23.00	02300	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	181,145	0	0	530,833	0	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	0	0	179	0	50.00
51.00	05100	0	0	0	0	0	51.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	0	0	0	48	0	54.00
55.00	05500	0	0	0	0	0	55.00
56.00	05600	0	0	0	0	0	56.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	0	0	0	0	0	60.00
60.01	06001	0	0	0	0	0	60.01
61.00	06100	0	0	0	0	0	61.00
62.00	06200	0	0	0	0	0	62.00
63.00	06300	0	0	0	0	0	63.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	0	0	0	137,122	0	65.00
66.00	06600	0	0	0	11,542	0	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	0	0	0	0	0	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	1,369,248	73.00
74.00	07400	0	0	0	0	0	74.00
75.00	07500	0	0	0	0	0	75.00
OTHER REIMBURSABLE COST CENTERS							
100.00	10000	0	0	0	0	0	100.00
SPECIAL PURPOSE COST CENTERS							
118.00		181,145	0	0	679,724	1,369,248	118.00
NONREIMBURSABLE COST CENTERS							
193.00	19300	0	0	0	0	0	193.00
194.00	07950	0	0	0	0	0	194.00
194.01	07952	0	0	0	0	0	194.01
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		181,145	0	0	679,724	1,369,248	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 152021

Period:
From 07/01/2011
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Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
			PASTORAL CARE			
	16.00	17.00	18.00	19.00	20.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS					4.00
5.00 00500	ADMINISTRATIVE & GENERAL					5.00
6.00 00601	MAINTENANCE & REPAIRS					6.00
7.00 00700	OPERATION OF PLANT					7.00
8.00 00800	LAUNDRY & LINEN SERVICE					8.00
9.00 00900	HOUSEKEEPING					9.00
10.00 01000	DIETARY					10.00
11.00 01100	CAFETERIA					11.00
12.00 01200	MAINTENANCE OF PERSONNEL					12.00
13.00 01300	NURSING ADMINISTRATION					13.00
15.00 01500	PHARMACY					15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	67,529				16.00
17.00 01700	SOCIAL SERVICE	0	109,806			17.00
18.00 01850	PASTORAL CARE	0	0	78,476		18.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00 02000	NURSING SCHOOL	0	0	0	0	20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	22.00
23.00 02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	25,764	109,806	78,476	0	30.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	1,669	0	0	0	50.00
51.00 05100	RECOVERY ROOM	0	0	0	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,523	0	0	0	54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
56.00 05600	RADIOISOTOPE	0	0	0	0	56.00
57.00 05700	CT SCAN	916	0	0	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00 06000	LABORATORY	6,914	0	0	0	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	60.01
61.00 06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	61.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	62.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	394	0	0	0	63.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	15,069	0	0	0	65.00
66.00 06600	PHYSICAL THERAPY	1,431	0	0	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	1,222	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	714	0	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY	960	0	0	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	39	0	0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	9,619	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	1,295	0	0	0	74.00
75.00 07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
OTHER REIMBURSABLE COST CENTERS						
100.00 10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	100.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	67,529	109,806	78,476	0	118.00
NONREIMBURSABLE COST CENTERS						
193.00 19300	NONPAID WORKERS	0	0	0	0	193.00
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.00
194.01 07952	MARKETING	0	0	0	0	194.01
200.00	Cross Foot Adjustments	0	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	67,529	109,806	78,476	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 152021

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Cost Center Description	INTERNS & RESIDENTS			PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments
	SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS				
	21.00	22.00	23.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS					4.00
5.00 00500	ADMINISTRATIVE & GENERAL					5.00
6.00 00601	MAINTENANCE & REPAIRS					6.00
7.00 00700	OPERATION OF PLANT					7.00
8.00 00800	LAUNDRY & LINEN SERVICE					8.00
9.00 00900	HOUSEKEEPING					9.00
10.00 01000	DIETARY					10.00
11.00 01100	CAFETERIA					11.00
12.00 01200	MAINTENANCE OF PERSONNEL					12.00
13.00 01300	NURSING ADMINISTRATION					13.00
15.00 01500	PHARMACY					15.00
16.00 01600	MEDICAL RECORDS & LIBRARY					16.00
17.00 01700	SOCIAL SERVICE					17.00
18.00 01850	PASTORAL CARE					18.00
19.00 01900	NONPHYSICIAN ANESTHETISTS					19.00
20.00 02000	NURSING SCHOOL					20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0				21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0			22.00
23.00 02300	PARAMED ED PRGM-(SPECIFY)	0	0	0		23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	0	0	6,453,743	30.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	0	0	140,506	50.00
51.00 05100	RECOVERY ROOM	0	0	0	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	0	308,603	54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
56.00 05600	RADIOISOTOPE	0	0	0	0	56.00
57.00 05700	CT SCAN	0	0	0	57,633	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00 06000	LABORATORY	0	0	0	324,125	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	60.01
61.00 06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	61.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	62.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	46,656	63.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	0	0	0	1,900,669	65.00
66.00 06600	PHYSICAL THERAPY	0	0	0	231,616	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	59,768	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	111,338	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	84,569	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	7,269	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,378,867	73.00
74.00 07400	RENAL DIALYSIS	0	0	0	202,941	74.00
75.00 07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
OTHER REIMBURSABLE COST CENTERS						
100.00 10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	100.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	0	0	11,308,303	118.00
NONREIMBURSABLE COST CENTERS						
193.00 19300	NONPAID WORKERS	0	0	0	0	193.00
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.00
194.01 07952	MARKETING	0	0	0	192,584	194.01
200.00	Cross Foot Adjustments	0	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	0	0	11,500,887	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
6.00	00601	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	12.00
13.00	01300	NURSING ADMINISTRATION	13.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
18.00	01850	PASTORAL CARE	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
20.00	02000	NURSING SCHOOL	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	6,453,743
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	140,506
51.00	05100	RECOVERY ROOM	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0
53.00	05300	ANESTHESIOLOGY	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	308,603
55.00	05500	RADIOLOGY-THERAPEUTIC	0
56.00	05600	RADIOISOTOPE	0
57.00	05700	CT SCAN	57,633
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0
59.00	05900	CARDIAC CATHETERIZATION	0
60.00	06000	LABORATORY	324,125
60.01	06001	BLOOD LABORATORY	0
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	46,656
64.00	06400	INTRAVENOUS THERAPY	0
65.00	06500	RESPIRATORY THERAPY	1,900,669
66.00	06600	PHYSICAL THERAPY	231,616
67.00	06700	OCCUPATIONAL THERAPY	59,768
68.00	06800	SPEECH PATHOLOGY	111,338
69.00	06900	ELECTROCARDIOLOGY	84,569
70.00	07000	ELECTROENCEPHALOGRAPHY	7,269
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0
73.00	07300	DRUGS CHARGED TO PATIENTS	1,378,867
74.00	07400	RENAL DIALYSIS	202,941
75.00	07500	ASC (NON-DISTINCT PART)	0
OTHER REIMBURSABLE COST CENTERS			
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0
SPECIAL PURPOSE COST CENTERS			
118.00	SUBTOTALS (SUM OF LINES 1-117)		11,308,303
NONREIMBURSABLE COST CENTERS			
193.00	19300	NONPAID WORKERS	0
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0
194.01	07952	MARKETING	192,584
200.00		Cross Foot Adjustments	0
201.00		Negative Cost Centers	0
202.00		TOTAL (sum lines 118-201)	11,500,887

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 152021

Period:
From 07/01/2011
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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	0	0	0	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	106,326	59,422	5.00
6.00 00601	MAINTENANCE & REPAIRS	0	0	0	6.00
7.00 00700	OPERATION OF PLANT	0	9,109	5,091	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	15,013	8,390	8.00
9.00 00900	HOUSEKEEPING	0	4,498	2,514	9.00
10.00 01000	DIETARY	0	18,049	10,087	10.00
11.00 01100	CAFETERIA	0	0	0	11.00
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	12.00
13.00 01300	NURSING ADMINISTRATION	0	36,941	20,645	13.00
15.00 01500	PHARMACY	0	28,845	16,120	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	8,322	4,651	16.00
17.00 01700	SOCIAL SERVICE	0	10,964	6,128	17.00
18.00 01850	PASTORAL CARE	0	0	0	18.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	19.00
20.00 02000	NURSING SCHOOL	0	0	0	20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	22.00
23.00 02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 03000	ADULTS & PEDIATRICS	0	425,528	237,811	30.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000	OPERATING ROOM	0	0	0	50.00
51.00 05100	RECOVERY ROOM	0	0	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00 05300	ANESTHESIOLOGY	0	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	0	0	0	55.00
56.00 05600	RADIOISOTOPE	0	0	0	56.00
57.00 05700	CT SCAN	0	0	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	59.00
60.00 06000	LABORATORY	0	7,984	4,462	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	60.01
61.00 06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	61.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	62.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	63.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	0	6,803	3,802	65.00
66.00 06600	PHYSICAL THERAPY	0	618	346	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	562	314	67.00
68.00 06800	SPEECH PATHOLOGY	0	337	189	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	0	0	0	74.00
75.00 07500	ASC (NON-DISTINCT PART)	0	0	0	75.00
OTHER REIMBURSABLE COST CENTERS					
100.00 10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	100.00
SPECIAL PURPOSE COST CENTERS					
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	679,899	379,972	118.00
NONREIMBURSABLE COST CENTERS					
193.00 19300	NONPAID WORKERS	0	0	0	193.00
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	194.00
194.01 07952	MARKETING	0	0	0	194.01
200.00	Cross Foot Adjustments			0	200.00
201.00	Negative Cost Centers		0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	679,899	379,972	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 152021

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Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	165,748				5.00
6.00	00601	MAINTENANCE & REPAIRS	0	0			6.00
7.00	00700	OPERATION OF PLANT	2,666		16,866		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	411	0	449	24,263	8.00
9.00	00900	HOUSEKEEPING	861	0	134	0	9.00
10.00	01000	DIETARY	2,496	0	539	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	9,562	0	1,104	0	13.00
15.00	01500	PHARMACY	19,551	0	862	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	920	0	249	0	16.00
17.00	01700	SOCIAL SERVICE	1,513	0	328	0	17.00
18.00	01850	PASTORAL CARE	1,131	0	0	0	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	76,483	0	12,714	24,263	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,998	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,425	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	817	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	4,521	0	239	117	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	667	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	25,156	0	203	100	65.00
66.00	06600	PHYSICAL THERAPY	3,147	0	18	9	66.00
67.00	06700	OCCUPATIONAL THERAPY	840	0	17	8	67.00
68.00	06800	SPEECH PATHOLOGY	1,592	0	10	5	68.00
69.00	06900	ELECTROCARDIOLOGY	1,205	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	104	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	2,906	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
OTHER REIMBURSABLE COST CENTERS							
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	100.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	162,972	0	16,866	24,263	118.00
NONREIMBURSABLE COST CENTERS							
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.00
194.01	07952	MARKETING	2,776	0	0	0	194.01
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	165,748	0	16,866	24,263	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 152021	Period: From 07/01/2011 To 06/30/2012	Worksheet B Part II Date/Time Prepared: 11/20/2012 4:58 pm			
Cost Center Description		DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	PHARMACY	
		10.00	11.00	12.00	13.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00601	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY	31,436				10.00
11.00	01100	CAFETERIA	0	0			11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0		12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	68,795	13.00
15.00	01500	PHARMACY	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	65,802	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
18.00	01850	PASTORAL CARE	0	0	0	0	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	31,436	0	0	53,726	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	18	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	5	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	13,878	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,168	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	IMPL. DEV. 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
OTHER REIMBURSABLE COST CENTERS							
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	100.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	31,436	0	0	68,795	118.00
NONREIMBURSABLE COST CENTERS							
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.00
194.01	07952	MARKETING	0	0	0	0	194.01
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	31,436	0	0	68,795	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 152021

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

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Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE PASTORAL CARE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
	16.00	17.00	18.00	19.00	20.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS					4.00
5.00 00500	ADMINISTRATIVE & GENERAL					5.00
6.00 00601	MAINTENANCE & REPAIRS					6.00
7.00 00700	OPERATION OF PLANT					7.00
8.00 00800	LAUNDRY & LINEN SERVICE					8.00
9.00 00900	HOUSEKEEPING					9.00
10.00 01000	DIETARY					10.00
11.00 01100	CAFETERIA					11.00
12.00 01200	MAINTENANCE OF PERSONNEL					12.00
13.00 01300	NURSING ADMINISTRATION					13.00
15.00 01500	PHARMACY					15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	14,264				16.00
17.00 01700	SOCIAL SERVICE	0	19,094			17.00
18.00 01850	PASTORAL CARE	0	0	1,131		18.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00 02000	NURSING SCHOOL	0	0	0	0	20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	22.00
23.00 02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	5,443	19,094	1,131		30.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	353	0	0		50.00
51.00 05100	RECOVERY ROOM	0	0	0		51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00 05300	ANESTHESIOLOGY	0	0	0		53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	322	0	0		54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	0	0	0		55.00
56.00 05600	RADIOISOTOPE	0	0	0		56.00
57.00 05700	CT SCAN	194	0	0		57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00 06000	LABORATORY	1,460	0	0		60.00
60.01 06001	BLOOD LABORATORY	0	0	0		60.01
61.00 06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0		61.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0		62.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	83	0	0		63.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0		64.00
65.00 06500	RESPIRATORY THERAPY	3,182	0	0		65.00
66.00 06600	PHYSICAL THERAPY	302	0	0		66.00
67.00 06700	OCCUPATIONAL THERAPY	258	0	0		67.00
68.00 06800	SPEECH PATHOLOGY	151	0	0		68.00
69.00 06900	ELECTROCARDIOLOGY	203	0	0		69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	8	0	0		70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	2,031	0	0		73.00
74.00 07400	RENAL DIALYSIS	274	0	0		74.00
75.00 07500	ASC (NON-DISTINCT PART)	0	0	0		75.00
OTHER REIMBURSABLE COST CENTERS						
100.00 10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0		100.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	14,264	19,094	1,131	0	118.00
NONREIMBURSABLE COST CENTERS						
193.00 19300	NONPAID WORKERS	0	0	0		193.00
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0		194.00
194.01 07952	MARKETING	0	0	0		194.01
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)	14,264	19,094	1,131	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 152021

Period:
From 07/01/2011
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Cost Center Description	INTERNS & RESIDENTS			PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments
	SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS				
	21.00	22.00	23.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS					4.00
5.00 00500	ADMINISTRATIVE & GENERAL					5.00
6.00 00601	MAINTENANCE & REPAIRS					6.00
7.00 00700	OPERATION OF PLANT					7.00
8.00 00800	LAUNDRY & LINEN SERVICE					8.00
9.00 00900	HOUSEKEEPING					9.00
10.00 01000	DIETARY					10.00
11.00 01100	CAFETERIA					11.00
12.00 01200	MAINTENANCE OF PERSONNEL					12.00
13.00 01300	NURSING ADMINISTRATION					13.00
15.00 01500	PHARMACY					15.00
16.00 01600	MEDICAL RECORDS & LIBRARY					16.00
17.00 01700	SOCIAL SERVICE					17.00
18.00 01850	PASTORAL CARE					18.00
19.00 01900	NONPHYSICIAN ANESTHETISTS					19.00
20.00 02000	NURSING SCHOOL					20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0				21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD		0			22.00
23.00 02300	PARAMED ED PRGM-(SPECIFY)			0		23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS				893,882	0 30.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM				2,369	0 50.00
51.00 05100	RECOVERY ROOM				0	0 51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM				0	0 52.00
53.00 05300	ANESTHESIOLOGY				0	0 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC				4,752	0 54.00
55.00 05500	RADIOLOGY-THERAPEUTIC				0	0 55.00
56.00 05600	RADIOISOTOPE				0	0 56.00
57.00 05700	CT SCAN				1,011	0 57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)				0	0 58.00
59.00 05900	CARDIAC CATHETERIZATION				0	0 59.00
60.00 06000	LABORATORY				18,783	0 60.00
60.01 06001	BLOOD LABORATORY				0	0 60.01
61.00 06100	PBP CLINICAL LAB SERVICES-PRGM ONLY				0	0 61.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS				0	0 62.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.				750	0 63.00
64.00 06400	INTRAVENOUS THERAPY				0	0 64.00
65.00 06500	RESPIRATORY THERAPY				53,124	0 65.00
66.00 06600	PHYSICAL THERAPY				5,608	0 66.00
67.00 06700	OCCUPATIONAL THERAPY				1,999	0 67.00
68.00 06800	SPEECH PATHOLOGY				2,284	0 68.00
69.00 06900	ELECTROCARDIOLOGY				1,408	0 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY				112	0 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS				0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS				0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS				67,833	0 73.00
74.00 07400	RENAL DIALYSIS				3,180	0 74.00
75.00 07500	ASC (NON-DISTINCT PART)				0	0 75.00
OTHER REIMBURSABLE COST CENTERS						
100.00 10000	I&R SERVICES-NOT APPRVD PRGM				0	0 100.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	0	0	1,057,095	0 118.00
NONREIMBURSABLE COST CENTERS						
193.00 19300	NONPAID WORKERS				0	0 193.00
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS				0	0 194.00
194.01 07952	MARKETING				2,776	0 194.01
200.00	Cross Foot Adjustments	0	0	0	0	0 200.00
201.00	Negative Cost Centers	0	0	0	0	0 201.00
202.00	TOTAL (sum lines 118-201)	0	0	0	1,059,871	0 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 152021

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

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100 CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400 EMPLOYEE BENEFITS		4.00
5.00	00500 ADMINISTRATIVE & GENERAL		5.00
6.00	00601 MAINTENANCE & REPAIRS		6.00
7.00	00700 OPERATION OF PLANT		7.00
8.00	00800 LAUNDRY & LINEN SERVICE		8.00
9.00	00900 HOUSEKEEPING		9.00
10.00	01000 DIETARY		10.00
11.00	01100 CAFETERIA		11.00
12.00	01200 MAINTENANCE OF PERSONNEL		12.00
13.00	01300 NURSING ADMINISTRATION		13.00
15.00	01500 PHARMACY		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY		16.00
17.00	01700 SOCIAL SERVICE		17.00
18.00	01850 PASTORAL CARE		18.00
19.00	01900 NONPHYSICIAN ANESTHETISTS		19.00
20.00	02000 NURSING SCHOOL		20.00
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRVD		21.00
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD		22.00
23.00	02300 PARAMED ED PRGM-(SPECIFY)		23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS	893,882	30.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	2,369	50.00
51.00	05100 RECOVERY ROOM	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	52.00
53.00	05300 ANESTHESIOLOGY	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	4,752	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	55.00
56.00	05600 RADIOISOTOPE	0	56.00
57.00	05700 CT SCAN	1,011	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	59.00
60.00	06000 LABORATORY	18,783	60.00
60.01	06001 BLOOD LABORATORY	0	60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	750	63.00
64.00	06400 INTRAVENOUS THERAPY	0	64.00
65.00	06500 RESPIRATORY THERAPY	53,124	65.00
66.00	06600 PHYSICAL THERAPY	5,608	66.00
67.00	06700 OCCUPATIONAL THERAPY	1,999	67.00
68.00	06800 SPEECH PATHOLOGY	2,284	68.00
69.00	06900 ELECTROCARDIOLOGY	1,408	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	112	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	67,833	73.00
74.00	07400 RENAL DIALYSIS	3,180	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	75.00
OTHER REIMBURSABLE COST CENTERS			
100.00	10000 I&R SERVICES-NOT APPRVD PRGM	0	100.00
SPECIAL PURPOSE COST CENTERS			
118.00	SUBTOTALS (SUM OF LINES 1-117)	1,057,095	118.00
NONREIMBURSABLE COST CENTERS			
193.00	19300 NONPAID WORKERS	0	193.00
194.00	07950 OTHER NONREIMBURSABLE COST CENTERS	0	194.00
194.01	07952 MARKETING	2,776	194.01
200.00	Cross Foot Adjustments	0	200.00
201.00	Negative Cost Centers	0	201.00
202.00	TOTAL (sum lines 118-201)	1,059,871	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 152021

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				
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	12,092				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		12,092			2.00
4.00	00400	EMPLOYEE BENEFITS	0	0	5,112,333		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,891	1,891	851,590	-2,071,364	5.00
6.00	00601	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	162	162	53,815	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	267	267	0	0	8.00
9.00	00900	HOUSEKEEPING	80	80	0	0	9.00
10.00	01000	DIETARY	321	321	0	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	657	657	367,435	0	13.00
15.00	01500	PHARMACY	513	513	377,126	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	148	148	17,328	0	16.00
17.00	01700	SOCIAL SERVICE	195	195	52,779	0	17.00
18.00	01850	PASTORAL CARE	0	0	48,684	0	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	7,568	7,568	2,574,235	0	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	1,721	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	469	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	142	142	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	121	121	741,406	0	65.00
66.00	06600	PHYSICAL THERAPY	11	11	25,745	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	10	10	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	6	6	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
OTHER REIMBURSABLE COST CENTERS							
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	100.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	12,092	12,092	5,112,333	-2,071,364	118.00
NONREIMBURSABLE COST CENTERS							
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.00
194.01	07952	MARKETING	0	0	0	0	194.01
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per wkst. B, Part I)	679,899	379,972	1,563,052	2,071,364	202.00
203.00		Unit cost multiplier (wkst. B, Part I)	56.227175	31.423420	0.305741	0.219668	203.00
204.00		Cost to be allocated (per wkst. B, Part II)			0	165,748	204.00
205.00		Unit cost multiplier (wkst. B, Part II)			0.000000	0.017578	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 152021

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

Worksheet B-1

Date/Time Prepared:
11/20/2012 4:58 pm

Cost Center Description		MAINTENANCE & REPAIRS (SQ. FEET)	OPERATION OF PLANT (SQ. FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQ. FEET)	DIETARY (TOTAL PATIENT DAYS)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00601	MAINTENANCE & REPAIRS	0				6.00
7.00	00700	OPERATION OF PLANT	0	10,039			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	267	100		8.00
9.00	00900	HOUSEKEEPING	0	80	0	9,692	9.00
10.00	01000	DIETARY	0	321	0	321	5,983
11.00	01100	CAFETERIA	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	657	0	657	13.00
15.00	01500	PHARMACY	0	513	0	513	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	148	0	148	16.00
17.00	01700	SOCIAL SERVICE	0	195	0	195	17.00
18.00	01850	PASTORAL CARE	0	0	0	0	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	7,568	100	7,568	5,983
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	142	0	142	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	121	0	121	65.00
66.00	06600	PHYSICAL THERAPY	0	11	0	11	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	10	0	10	67.00
68.00	06800	SPEECH PATHOLOGY	0	6	0	6	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
OTHER REIMBURSABLE COST CENTERS							
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	100.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	10,039	100	9,692	5,983
NONREIMBURSABLE COST CENTERS							
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.00
194.01	07952	MARKETING	0	0	0	0	194.01
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	184,987	33,464	61,191	181,145
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	18.426835	334.640000	6.313558	30.276617
204.00		Cost to be allocated (per Wkst. B, Part II)	0	16,866	24,263	8,007	31,436
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	1.680048	242.630000	0.826145	5.254220

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 152021

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

Worksheet B-1

Date/Time Prepared:
11/20/2012 4:58 pm

Cost Center Description		CAFETERIA (MEALS SERVED)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
		11.00	12.00	13.00	15.00	16.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS					4.00	
5.00	00500	ADMINISTRATIVE & GENERAL					5.00	
6.00	00601	MAINTENANCE & REPAIRS					6.00	
7.00	00700	OPERATION OF PLANT					7.00	
8.00	00800	LAUNDRY & LINEN SERVICE					8.00	
9.00	00900	HOUSEKEEPING					9.00	
10.00	01000	DIETARY					10.00	
11.00	01100	CAFETERIA	0				11.00	
12.00	01200	MAINTENANCE OF PERSONNEL	0	0			12.00	
13.00	01300	NURSING ADMINISTRATION	0	0	113,661		13.00	
15.00	01500	PHARMACY	0	0	0	100	15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	27,159,002	16.00	
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00	
18.00	01850	PASTORAL CARE	0	0	0	0	18.00	
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00	
20.00	02000	NURSING SCHOOL	0	0	0	0	20.00	
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	21.00	
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	22.00	
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	88,764	0	10,358,971	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	30	0	671,474	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	8	0	612,543	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	368,664	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	2,781,229	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	158,420	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	22,929	0	6,061,478	65.00
66.00	06600	PHYSICAL THERAPY	0	0	1,930	0	575,611	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	491,534	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	287,055	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	386,063	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	15,811	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	100	3,869,142	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	521,007	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
OTHER REIMBURSABLE COST CENTERS								
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	0	113,661	100	27,159,002	118.00
NONREIMBURSABLE COST CENTERS								
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07952	MARKETING	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per wkst. B, Part I)	0	0	679,724	1,369,248	67,529	202.00
203.00		Unit cost multiplier (wkst. B, Part I)	0.000000	0.000000	5.980275	13,692.480000	0.002486	203.00
204.00		Cost to be allocated (per wkst. B, Part II)	0	0	68,795	65,802	14,264	204.00
205.00		Unit cost multiplier (wkst. B, Part II)	0.000000	0.000000	0.605265	658.020000	0.000525	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 152021

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

Worksheet B-1

Date/Time Prepared:
11/20/2012 4:58 pm

Cost Center Description	SOCIAL SERVICE	OTHER GENERAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
	(TOTAL PATIENT DAYS)	PASTORAL CARE (TOTAL PATIENT DAYS)	(ASSIGNED TIME)	(ASSIGNED TIME)	
	17.00	18.00	19.00	20.00	
GENERAL SERVICE COST CENTERS					
1.00 00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00 00400	EMPLOYEE BENEFITS				4.00
5.00 00500	ADMINISTRATIVE & GENERAL				5.00
6.00 00601	MAINTENANCE & REPAIRS				6.00
7.00 00700	OPERATION OF PLANT				7.00
8.00 00800	LAUNDRY & LINEN SERVICE				8.00
9.00 00900	HOUSEKEEPING				9.00
10.00 01000	DIETARY				10.00
11.00 01100	CAFETERIA				11.00
12.00 01200	MAINTENANCE OF PERSONNEL				12.00
13.00 01300	NURSING ADMINISTRATION				13.00
15.00 01500	PHARMACY				15.00
16.00 01600	MEDICAL RECORDS & LIBRARY				16.00
17.00 01700	SOCIAL SERVICE	5,983			17.00
18.00 01850	PASTORAL CARE		5,983		18.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	19.00
20.00 02000	NURSING SCHOOL	0	0	0	20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	22.00
23.00 02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 03000	ADULTS & PEDIATRICS	5,983	5,983	0	30.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000	OPERATING ROOM	0	0	0	50.00
51.00 05100	RECOVERY ROOM	0	0	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00 05300	ANESTHESIOLOGY	0	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	0	0	0	55.00
56.00 05600	RADIOISOTOPE	0	0	0	56.00
57.00 05700	CT SCAN	0	0	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	59.00
60.00 06000	LABORATORY	0	0	0	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	60.01
61.00 06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	61.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	62.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	63.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	0	0	0	65.00
66.00 06600	PHYSICAL THERAPY	0	0	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00 07200	IMPL. DEV. 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
OTHER REIMBURSABLE COST CENTERS					
100.00 10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	100.00
SPECIAL PURPOSE COST CENTERS					
118.00	SUBTOTALS (SUM OF LINES 1-117)	5,983	5,983	0	118.00
NONREIMBURSABLE COST CENTERS					
193.00 19300	NONPAID WORKERS	0	0	0	193.00
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	194.00
194.01 07952	MARKETING	0	0	0	194.01
200.00	Cross Foot Adjustments				200.00
201.00	Negative Cost Centers				201.00
202.00	Cost to be allocated (per wkst. B, Part I)	109,806	78,476	0	202.00
203.00	Unit cost multiplier (wkst. B, Part I)	18.353000	13.116497	0.000000	203.00
204.00	Cost to be allocated (per wkst. B, Part II)	19,094	1,131	0	204.00
205.00	Unit cost multiplier (wkst. B, Part II)	3.191376	0.189036	0.000000	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 152021

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

Worksheet B-1

Date/Time Prepared:
11/20/2012 4:58 pm

Cost Center Description	INTERNS & RESIDENTS			PARAMED ED PRGM (ASSIGNED TIME)		
	SERVICES-SALARY & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)				
	21.00	22.00	23.00			
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
6.00	00601	MAINTENANCE & REPAIRS				6.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
12.00	01200	MAINTENANCE OF PERSONNEL				12.00
13.00	01300	NURSING ADMINISTRATION				13.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
18.00	01850	PASTORAL CARE				18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
20.00	02000	NURSING SCHOOL				20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD		0		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)			0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00	07200	IMPL. DEV. 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
OTHER REIMBURSABLE COST CENTERS						
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	100.00
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	0	0	118.00
NONREIMBURSABLE COST CENTERS						
193.00	19300	NONPAID WORKERS	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	194.00
194.01	07952	MARKETING	0	0	0	194.01
200.00		Cross Foot Adjustments				200.00
201.00		Negative Cost Centers				201.00
202.00		Cost to be allocated (per wkst. B, Part I)	0	0	0	202.00
203.00		Unit cost multiplier (wkst. B, Part I)	0.000000	0.000000	0.000000	203.00
204.00		Cost to be allocated (per wkst. B, Part II)	0	0	0	204.00
205.00		Unit cost multiplier (wkst. B, Part II)	0.000000	0.000000	0.000000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 152021

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

Worksheet C
Part I
Date/Time Prepared:
11/20/2012 4:58 pm

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Title XVIII		Hospital		PPS
				Total Costs	RCE Disallowance	Total Costs		
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	6,453,743		6,453,743	0	6,453,743	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	140,506		140,506	0	140,506	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	308,603		308,603	0	308,603	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0		0	0	0	55.00
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
57.00	05700	CT SCAN	57,633		57,633	0	57,633	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	324,125		324,125	0	324,125	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0		0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0		0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	46,656		46,656	0	46,656	63.00
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,900,669	0	1,900,669	0	1,900,669	65.00
66.00	06600	PHYSICAL THERAPY	231,616	0	231,616	0	231,616	66.00
67.00	06700	OCCUPATIONAL THERAPY	59,768	0	59,768	0	59,768	67.00
68.00	06800	SPEECH PATHOLOGY	111,338	0	111,338	0	111,338	68.00
69.00	06900	ELECTROCARDIOLOGY	84,569		84,569	0	84,569	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	7,269		7,269	0	7,269	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,378,867		1,378,867	0	1,378,867	73.00
74.00	07400	RENAL DIALYSIS	202,941		202,941	0	202,941	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0		0	0	0	75.00
OTHER REIMBURSABLE COST CENTERS								
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0		0	0	0	100.00
200.00		Subtotal (see instructions)	11,308,303	0	11,308,303	0	11,308,303	200.00
201.00		Less Observation Beds	0		0	0	0	201.00
202.00		Total (see instructions)	11,308,303	0	11,308,303	0	11,308,303	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 152021

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

Worksheet C
Part I
Date/Time Prepared:
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		Title XVIII			Hospital	PPS
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
	9.00	10.00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,358,971		10,358,971	30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	671,474	0	671,474	50.00
51.00	05100	RECOVERY ROOM	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	612,543	0	612,543	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	56.00
57.00	05700	CT SCAN	368,664	0	368,664	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000	LABORATORY	2,781,229	0	2,781,229	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	158,420	0	158,420	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	6,061,478	0	6,061,478	65.00
66.00	06600	PHYSICAL THERAPY	575,611	0	575,611	66.00
67.00	06700	OCCUPATIONAL THERAPY	491,534	0	491,534	67.00
68.00	06800	SPEECH PATHOLOGY	287,055	0	287,055	68.00
69.00	06900	ELECTROCARDIOLOGY	386,063	0	386,063	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	15,811	0	15,811	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,869,142	0	3,869,142	73.00
74.00	07400	RENAL DIALYSIS	521,007	0	521,007	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	75.00
OTHER REIMBURSABLE COST CENTERS						
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	100.00
200.00		Subtotal (see instructions)	27,159,002	0	27,159,002	200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)	27,159,002	0	27,159,002	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 152021

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

Worksheet C
Part I
Date/Time Prepared:
11/20/2012 4:58 pm

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.209250			50.00
51.00	05100 RECOVERY ROOM	0.000000			51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	05300 ANESTHESIOLOGY	0.000000			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.503806			54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000			55.00
56.00	05600 RADIOISOTOPE	0.000000			56.00
57.00	05700 CT SCAN	0.156329			57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000			58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000			59.00
60.00	06000 LABORATORY	0.116540			60.00
60.01	06001 BLOOD LABORATORY	0.000000			60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000			61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000			62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.294508			63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000			64.00
65.00	06500 RESPIRATORY THERAPY	0.313565			65.00
66.00	06600 PHYSICAL THERAPY	0.402383			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.121595			67.00
68.00	06800 SPEECH PATHOLOGY	0.387863			68.00
69.00	06900 ELECTROCARDIOLOGY	0.219055			69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.459743			70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.356375			73.00
74.00	07400 RENAL DIALYSIS	0.389517			74.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000			75.00
OTHER REIMBURSABLE COST CENTERS					
100.00	10000 I&R SERVICES-NOT APPRVD PRGM				100.00
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: 152021

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

Worksheet C
Part I
Date/Time Prepared:
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Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Title XIX		Hospital		Total Costs
				Total Costs	RCE Disallowance	Total Costs	Cost	
				1.00	2.00	3.00	4.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	6,453,743		6,453,743	0	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	140,506		140,506	0	0	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	308,603		308,603	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0		0	0	0	55.00
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
57.00	05700	CT SCAN	57,633		57,633	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	324,125		324,125	0	0	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0		0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0		0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	46,656		46,656	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,900,669	0	1,900,669	0	0	65.00
66.00	06600	PHYSICAL THERAPY	231,616	0	231,616	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	59,768	0	59,768	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	111,338	0	111,338	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	84,569		84,569	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	7,269		7,269	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,378,867		1,378,867	0	0	73.00
74.00	07400	RENAL DIALYSIS	202,941		202,941	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0		0	0	0	75.00
OTHER REIMBURSABLE COST CENTERS								
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0		0	0	0	100.00
200.00		Subtotal (see instructions)	11,308,303	0	11,308,303	0	0	200.00
201.00		Less Observation Beds	0		0	0	0	201.00
202.00		Total (see instructions)	11,308,303	0	11,308,303	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 152021

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

Worksheet C
Part I
Date/Time Prepared:
11/20/2012 4:58 pm

Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	Cost
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,358,971		10,358,971	30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	671,474	0	671,474	0.209250
51.00	05100	RECOVERY ROOM	0	0	0	0.000000
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	612,543	0	612,543	0.503806
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0.000000
56.00	05600	RADIOISOTOPE	0	0	0	0.000000
57.00	05700	CT SCAN	368,664	0	368,664	0.156329
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000
60.00	06000	LABORATORY	2,781,229	0	2,781,229	0.116540
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0.000000
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0.000000
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	158,420	0	158,420	0.294508
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000
65.00	06500	RESPIRATORY THERAPY	6,061,478	0	6,061,478	0.313565
66.00	06600	PHYSICAL THERAPY	575,611	0	575,611	0.402383
67.00	06700	OCCUPATIONAL THERAPY	491,534	0	491,534	0.121595
68.00	06800	SPEECH PATHOLOGY	287,055	0	287,055	0.387863
69.00	06900	ELECTROCARDIOLOGY	386,063	0	386,063	0.219055
70.00	07000	ELECTROENCEPHALOGRAPHY	15,811	0	15,811	0.459743
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	3,869,142	0	3,869,142	0.356375
74.00	07400	RENAL DIALYSIS	521,007	0	521,007	0.389517
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000
OTHER REIMBURSABLE COST CENTERS						
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	100.00
200.00		Subtotal (see instructions)	27,159,002	0	27,159,002	200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)	27,159,002	0	27,159,002	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 152021

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

Worksheet C
Part I
Date/Time Prepared:
11/20/2012 4:58 pm

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000			50.00
51.00	05100 RECOVERY ROOM	0.000000			51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	05300 ANESTHESIOLOGY	0.000000			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000			55.00
56.00	05600 RADIOISOTOPE	0.000000			56.00
57.00	05700 CT SCAN	0.000000			57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000			58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000			59.00
60.00	06000 LABORATORY	0.000000			60.00
60.01	06001 BLOOD LABORATORY	0.000000			60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000			61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000			62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000			63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000			64.00
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800 SPEECH PATHOLOGY	0.000000			68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200 IMPL. DEV. 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
OTHER REIMBURSABLE COST CENTERS					
100.00	10000 I&R SERVICES-NOT APPRVD PRGM				100.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 152021

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

Worksheet D
Part I
Date/Time Prepared:
11/20/2012 4:58 pm

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	PPS	
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	893,882	0	893,882	5,983	149.40	30.00
200.00		Total (lines 30-199)	893,882		893,882	5,983		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 152021

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

Worksheet D
Part I
Date/Time Prepared:
11/20/2012 4:58 pm

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	4,272	638,237
200.00		Total (lines 30-199)	4,272	638,237
				30.00
				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 152021

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

Worksheet D
Part II
Date/Time Prepared:
11/20/2012 4:58 pm

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Hospital Inpatient Program Charges	Capital Costs (column 3 x column 4)	PPS	
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,369	671,474	0.003528	424,096	1,496	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,752	612,543	0.007758	418,579	3,247	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0.000000	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	1,011	368,664	0.002742	200,319	549	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	18,783	2,781,229	0.006753	2,030,818	13,714	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0.000000	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.000000	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	750	158,420	0.004734	147,775	700	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	53,124	6,061,478	0.008764	4,513,312	39,555	65.00
66.00	06600	PHYSICAL THERAPY	5,608	575,611	0.009743	424,929	4,140	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,999	491,534	0.004067	346,359	1,409	67.00
68.00	06800	SPEECH PATHOLOGY	2,284	287,055	0.007957	207,333	1,650	68.00
69.00	06900	ELECTROCARDIOLOGY	1,408	386,063	0.003647	101,970	372	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	112	15,811	0.007084	10,264	73	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	67,833	3,869,142	0.017532	2,450,102	42,955	73.00
74.00	07400	RENAL DIALYSIS	3,180	521,007	0.006104	441,287	2,694	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
200.00		Total (lines 50-199)	163,213	16,800,031		11,717,143	112,554	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 152021		Period: From 07/01/2011 To 06/30/2012		Worksheet D Part III Date/Time Prepared: 11/20/2012 4:58 pm	
Cost Center Description		Title XVIII			Hospital	PPS	
		Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	30.00
200.00		Total (lines 30-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 152021		Period: From 07/01/2011 To 06/30/2012		Worksheet D Part III Date/Time Prepared: 11/20/2012 4:58 pm		
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. Nursing School	
			6.00	7.00	8.00	9.00	11.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	5,983	0.00	4,272	0	0	30.00
200.00		Total (lines 30-199)	5,983		4,272	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 152021		Period: From 07/01/2011 To 06/30/2012		Worksheet D Part III Date/Time Prepared: 11/20/2012 4:58 pm	
Title XVIII				Hospital		PPS	
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: 152021

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

Worksheet D
Part IV
Date/Time Prepared:
11/20/2012 4:58 pm

Cost Center Description		Title XVIII				Hospital	PPS	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
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
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: 152021

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

Worksheet D
Part IV
Date/Time Prepared:
11/20/2012 4:58 pm

Cost Center Description		Title XVIII			Hospital		PPS	
		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	671,474	0.000000	0.000000	424,096	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	612,543	0.000000	0.000000	418,579	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0.000000	0.000000	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
57.00	05700	CT SCAN	0	368,664	0.000000	0.000000	200,319	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	2,781,229	0.000000	0.000000	2,030,818	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0.000000	0.000000	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.000000	0.000000	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	158,420	0.000000	0.000000	147,775	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	6,061,478	0.000000	0.000000	4,513,312	65.00
66.00	06600	PHYSICAL THERAPY	0	575,611	0.000000	0.000000	424,929	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	491,534	0.000000	0.000000	346,359	67.00
68.00	06800	SPEECH PATHOLOGY	0	287,055	0.000000	0.000000	207,333	68.00
69.00	06900	ELECTROCARDIOLOGY	0	386,063	0.000000	0.000000	101,970	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	15,811	0.000000	0.000000	10,264	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,869,142	0.000000	0.000000	2,450,102	73.00
74.00	07400	RENAL DIALYSIS	0	521,007	0.000000	0.000000	441,287	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0.000000	0	75.00
200.00		Total (lines 50-199)	0	16,800,031			11,717,143	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 152021

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

Worksheet D
Part IV
Date/Time Prepared:
11/20/2012 4:58 pm

Cost Center Description		Title XVIII			Hospital	PPS	
		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj.-Non Physician Anesthetist Cost	PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. 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
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 152021

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

Worksheet D
Part IV
Date/Time Prepared:
11/20/2012 4:58 pm

Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	Title XVIII	Hospital	PPS
ANCILLARY SERVICE COST CENTERS		23.00	24.00			
50.00	05000 OPERATING ROOM	0	0			50.00
51.00	05100 RECOVERY ROOM	0	0			51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0			52.00
53.00	05300 ANESTHESIOLOGY	0	0			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0			54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0			55.00
56.00	05600 RADIOISOTOPE	0	0			56.00
57.00	05700 CT SCAN	0	0			57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0			58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0			59.00
60.00	06000 LABORATORY	0	0			60.00
60.01	06001 BLOOD LABORATORY	0	0			60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0			61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0			62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0			63.00
64.00	06400 INTRAVENOUS THERAPY	0	0			64.00
65.00	06500 RESPIRATORY THERAPY	0	0			65.00
66.00	06600 PHYSICAL THERAPY	0	0			66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0			67.00
68.00	06800 SPEECH PATHOLOGY	0	0			68.00
69.00	06900 ELECTROCARDIOLOGY	0	0			69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0			70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			71.00
72.00	07200 IMPL. DEV. 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
200.00	Total (lines 50-199)	0	0			200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 152021	Period: From 07/01/2011 To 06/30/2012	Worksheet D Part V Date/Time Prepared: 11/20/2012 4:58 pm
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Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges				PPS	
		PPS Reimbursed Services (see instructions)	Hospital		PPS		
			Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)			PPS
	1.00	2.00	3.00	4.00			
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.209250	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.503806	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	56.00
57.00	05700	CT SCAN	0.156329	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	59.00
60.00	06000	LABORATORY	0.116540	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.294508	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.313565	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.402383	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.121595	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.387863	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.219055	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.459743	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.356375	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.389517	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	75.00
200.00		Subtotal (see instructions)		0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 152021	Period: From 07/01/2011 To 06/30/2012	Worksheet D Part V Date/Time Prepared: 11/20/2012 4:58 pm
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Cost Center Description	Costs			Hospital	PPS	
	PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)			
	5.00	6.00	7.00			
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00	07200	IMPL. DEV. 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
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: 152021

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

Worksheet D
Part I
Date/Time Prepared:
11/20/2012 4:58 pm

Cost Center Description	Title XIX			Hospital		Per Diem (col. 3 / col. 4)		
	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Cost			
	1.00	2.00	3.00	4.00	5.00			
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	893,882	0	893,882	5,983	149.40	30.00
200.00		Total (lines 30-199)	893,882		893,882	5,983		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 152021	Period: From 07/01/2011 To 06/30/2012	Worksheet D Part I Date/Time Prepared: 11/20/2012 4:58 pm
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	Cost
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS	277	41,384	30.00
200.00	Total (lines 30-199)	277	41,384	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 152021

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

Worksheet D
Part II
Date/Time Prepared:
11/20/2012 4:58 pm

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Hospital Inpatient Program Charges	Capital Costs (column 3 x column 4)	Cost	
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,369	671,474	0.003528	111,672	394	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,752	612,543	0.007758	67,759	526	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0.000000	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	1,011	368,664	0.002742	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	18,783	2,781,229	0.006753	101,360	684	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0.000000	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.000000	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	750	158,420	0.004734	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	53,124	6,061,478	0.008764	382,026	3,348	65.00
66.00	06600	PHYSICAL THERAPY	5,608	575,611	0.009743	13,310	130	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,999	491,534	0.004067	20,596	84	67.00
68.00	06800	SPEECH PATHOLOGY	2,284	287,055	0.007957	12,086	96	68.00
69.00	06900	ELECTROCARDIOLOGY	1,408	386,063	0.003647	11,223	41	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	112	15,811	0.007084	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	67,833	3,869,142	0.017532	207,548	3,639	73.00
74.00	07400	RENAL DIALYSIS	3,180	521,007	0.006104	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
200.00		Total (lines 50-199)	163,213	16,800,031		927,580	8,942	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 152021		Period: From 07/01/2011 To 06/30/2012		Worksheet D Part III Date/Time Prepared: 11/20/2012 4:58 pm	
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		0 200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 152021		Period: From 07/01/2011 To 06/30/2012		Worksheet D Part III Date/Time Prepared: 11/20/2012 4:58 pm		
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. Nursing School Cost	
			6.00	7.00	8.00	9.00	11.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	5,983	0.00	277	0	0	30.00
200.00		Total (lines 30-199)	5,983		277	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 152021

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

Worksheet D
Part III
Date/Time Prepared:
11/20/2012 4:58 pm

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: 152021

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

Worksheet D
Part IV
Date/Time Prepared:
11/20/2012 4:58 pm

Cost Center Description	Title XIX				Hospital	Cost	Total Cost (sum of col. 1 through col. 4)	
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost				
	1.00	2.00	3.00	4.00	5.00			
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
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
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: 152021

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

Worksheet D
Part IV
Date/Time Prepared:
11/20/2012 4:58 pm

Cost Center Description		Title XIX			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	671,474	0.000000	0.000000	111,672	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	612,543	0.000000	0.000000	67,759	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0.000000	0.000000	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
57.00	05700	CT SCAN	0	368,664	0.000000	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	2,781,229	0.000000	0.000000	101,360	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0.000000	0.000000	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.000000	0.000000	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	158,420	0.000000	0.000000	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	6,061,478	0.000000	0.000000	382,026	65.00
66.00	06600	PHYSICAL THERAPY	0	575,611	0.000000	0.000000	13,310	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	491,534	0.000000	0.000000	20,596	67.00
68.00	06800	SPEECH PATHOLOGY	0	287,055	0.000000	0.000000	12,086	68.00
69.00	06900	ELECTROCARDIOLOGY	0	386,063	0.000000	0.000000	11,223	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	15,811	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,869,142	0.000000	0.000000	207,548	73.00
74.00	07400	RENAL DIALYSIS	0	521,007	0.000000	0.000000	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0.000000	0	75.00
200.00		Total (lines 50-199)	0	16,800,031			927,580	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 152021

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

Worksheet D
Part IV
Date/Time Prepared:
11/20/2012 4:58 pm

Cost Center Description	Title XIX			Hospital	Cost		
	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School		
	11.00	12.00	13.00	21.00	22.00		
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. 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
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 152021

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

Worksheet D
Part IV
Date/Time Prepared:
11/20/2012 4:58 pm

Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	Title XIX	Hospital	Cost
ANCILLARY SERVICE COST CENTERS		23.00	24.00			
50.00	05000 OPERATING ROOM	0	0			50.00
51.00	05100 RECOVERY ROOM	0	0			51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0			52.00
53.00	05300 ANESTHESIOLOGY	0	0			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0			54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0			55.00
56.00	05600 RADIOISOTOPE	0	0			56.00
57.00	05700 CT SCAN	0	0			57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0			58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0			59.00
60.00	06000 LABORATORY	0	0			60.00
60.01	06001 BLOOD LABORATORY	0	0			60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0			61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0			62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0			63.00
64.00	06400 INTRAVENOUS THERAPY	0	0			64.00
65.00	06500 RESPIRATORY THERAPY	0	0			65.00
66.00	06600 PHYSICAL THERAPY	0	0			66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0			67.00
68.00	06800 SPEECH PATHOLOGY	0	0			68.00
69.00	06900 ELECTROCARDIOLOGY	0	0			69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0			70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			71.00
72.00	07200 IMPL. DEV. 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
200.00	Total (lines 50-199)	0	0			200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 152021	Period: From 07/01/2011 To 06/30/2012	Worksheet D-1 Date/Time Prepared: 11/20/2012 4:58 pm
Cost Center Description		Title XVIII	Hospital	PPS
PART I - ALL PROVIDER COMPONENTS				1.00
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			5,983 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			5,983 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)			5,983 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			0 5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			0 7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			4,272 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			0.00 17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			0.00 18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			0.00 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			0.00 20.00
21.00	Total general inpatient routine service cost (see instructions)			6,453,743 21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)			0 22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)			0 23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			0 24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)			0 25.00
26.00	Total swing-bed cost (see instructions)			0 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			6,453,743 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)			10,358,971 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			10,358,971 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.623010 31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00 32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			1,731.40 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)			6,453,743 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)			1,078.68 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			4,608,121 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)			4,608,121 41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 152021	Period: From 07/01/2011 To 06/30/2012	Worksheet D-1 Date/Time Prepared: 11/20/2012 4:58 pm
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Cost Center Description	Title XVIII			Hospital	PPS
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	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)					3,391,968
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					8,000,089
PASS THROUGH COST ADJUSTMENTS					
50.00 Pass through costs applicable to Program inpatient routine services (from wkst. D, sum of Parts I and III)					638,237
51.00 Pass through costs applicable to Program inpatient ancillary services (from wkst. D, sum of Parts II and IV)					112,554
52.00 Total Program excludable cost (sum of lines 50 and 51)					750,791
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					7,249,298
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00 Program discharges					0
55.00 Target amount per discharge					0.00
56.00 Target amount (line 54 x line 55)					0
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00 Bonus payment (see instructions)					0
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
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
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
62.00 Relief payment (see instructions)					0
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0
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
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
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
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
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
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)					0
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 152021

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

Worksheet D-1

Date/Time Prepared:
11/20/2012 4:58 pm

Cost Center Description	Cost	Title XVIII		Hospital	PPS	
		Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	893,882	6,453,743	0.138506	0	0	90.00
91.00 Nursing School cost	0	6,453,743	0.000000	0	0	91.00
92.00 Allied health cost	0	6,453,743	0.000000	0	0	92.00
93.00 All other Medical Education	0	6,453,743	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 152021	Period: From 07/01/2011 To 06/30/2012	Worksheet D-1 Date/Time Prepared: 11/20/2012 4:58 pm
Cost Center Description		Title XIX	Hospital	Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			5,983 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			5,983 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)			5,983 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			0 5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			0 7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			277 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			0.00 17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			0.00 18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			0.00 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			0.00 20.00
21.00	Total general inpatient routine service cost (see instructions)			6,453,743 21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)			0 22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)			0 23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			0 24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)			0 25.00
26.00	Total swing-bed cost (see instructions)			0 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			6,453,743 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)			10,358,971 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			10,358,971 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.623010 31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00 32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			1,731.40 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)			6,453,743 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)			1,078.68 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			298,794 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)			298,794 41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 152021

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

Worksheet D-1

Date/Time Prepared:
11/20/2012 4:58 pm

Cost Center Description	Title XIX			Hospital	Cost
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 + col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00 NURSERY (title V & XIX only)					42.00
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT					43.00
44.00 CORONARY CARE UNIT					44.00
45.00 BURN INTENSIVE CARE UNIT					45.00
46.00 SURGICAL INTENSIVE CARE UNIT					46.00
47.00 OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description					1.00
48.00 Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					278,077
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					576,871
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
51.00 Pass through costs applicable to Program inpatient ancillary services (from wkst. D, sum of Parts II and IV)					0
52.00 Total Program excludable cost (sum of lines 50 and 51)					0
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00 Program discharges					0
55.00 Target amount per discharge					0.00
56.00 Target amount (line 54 x line 55)					0
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00 Bonus payment (see instructions)					0
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
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
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
62.00 Relief payment (see instructions)					0
63.00 Allowable inpatient cost plus incentive payment (see instructions)					0
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
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
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
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
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
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)					0
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 152021		Period: From 07/01/2011 To 06/30/2012		Worksheet D-1 Date/Time Prepared: 11/20/2012 4:58 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Hospital Total Observation Bed Cost (from line 89)	Cost 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: 152021	Period: From 07/01/2011 To 06/30/2012	Worksheet D-3 Date/Time Prepared: 11/20/2012 4:58 pm	
Cost Center Description		Ratio of Cost To Charges	Hospital Inpatient Program Charges	PPS Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		7,218,728		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.209250	424,096	88,742	50.00
51.00	05100 RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.503806	418,579	210,883	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	55.00
56.00	05600 RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700 CT SCAN	0.156329	200,319	31,316	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000 LABORATORY	0.116540	2,030,818	236,672	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	0	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.294508	147,775	43,521	63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.313565	4,513,312	1,415,217	65.00
66.00	06600 PHYSICAL THERAPY	0.402383	424,929	170,984	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.121595	346,359	42,116	67.00
68.00	06800 SPEECH PATHOLOGY	0.387863	207,333	80,417	68.00
69.00	06900 ELECTROCARDIOLOGY	0.219055	101,970	22,337	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.459743	10,264	4,719	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.356375	2,450,102	873,155	73.00
74.00	07400 RENAL DIALYSIS	0.389517	441,287	171,889	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
200.00	Total (sum of lines 50-94 and 96-98)		11,717,143	3,391,968	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)		11,717,143		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 152021	Period: From 07/01/2011 To 06/30/2012	Worksheet D-3 Date/Time Prepared: 11/20/2012 4:58 pm
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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		483,283		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.209250	111,672	23,367	50.00
51.00	05100 RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.503806	67,759	34,137	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	55.00
56.00	05600 RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700 CT SCAN	0.156329	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000 LABORATORY	0.116540	101,360	11,812	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	0	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.294508	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.313565	382,026	119,790	65.00
66.00	06600 PHYSICAL THERAPY	0.402383	13,310	5,356	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.121595	20,596	2,504	67.00
68.00	06800 SPEECH PATHOLOGY	0.387863	12,086	4,688	68.00
69.00	06900 ELECTROCARDIOLOGY	0.219055	11,223	2,458	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.459743	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.356375	207,548	73,965	73.00
74.00	07400 RENAL DIALYSIS	0.389517	0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
200.00	Total (sum of lines 50-94 and 96-98)		927,580	278,077	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)		927,580		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 152021	Period: From 07/01/2011 To 06/30/2012	Worksheet E Part B Date/Time Prepared: 11/20/2012 4:58 pm
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPSS (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)		0	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from worksheet D-4, Part III, line 69, col. 4)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)		0	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)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		0	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)		0	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)		0	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		0	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)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)		0	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)		0	40.00
41.00	Interim payments		0	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)		0	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: 152021	Period: From 07/01/2011 To 06/30/2012	Worksheet E Part B Date/Time Prepared: 11/20/2012 4:58 pm
		Title XVIII	Hospital	PPS
				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: 152021

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

Worksheet E-1
Part I
Date/Time Prepared:
11/20/2012 4:58 pm

		Title XVIII		Hospital	PPS
		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		6,700,345		0
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
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
3.02			0		0
3.03			0		0
3.04			0		0
3.05			0		0
Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0
3.51			0		0
3.52			0		0
3.53			0		0
3.54			0		0
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0
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)		6,700,345		0
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
5.02			0		0
5.03			0		0
Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0
5.51			0		0
5.52			0		0
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				6.00
6.01	SETTLEMENT TO PROVIDER		74,612		0
6.02	SETTLEMENT TO PROGRAM		0		0
7.00	Total Medicare program liability (see instructions)		6,774,957		0
				Contractor Number	Date (Mo/Day/Yr)
				0	1.00 2.00
8.00	Name of Contractor				8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 152021	Period: From 07/01/2011 To 06/30/2012	Worksheet E-3 Part IV Date/Time Prepared: 11/20/2012 4:58 pm
		Title XVIII	Hospital	PPS
		1.00		
PART IV - MEDICARE PART A SERVICES - LTCH PPS				
1.00	Net Federal PPS Payments (see instructions)		6,209,232	1.00
2.00	Outlier Payments		711,330	2.00
3.00	Total PPS Payments (sum of lines 1 and 2)		6,920,562	3.00
4.00	Nursing and Allied Health Managed Care payments (see instructions)		0	4.00
5.00	Organ acquisition		0	5.00
6.00	Cost of teaching physicians		0	6.00
7.00	Subtotal (see instructions)		6,920,562	7.00
8.00	Primary payer payments		0	8.00
9.00	Subtotal (line 7 less line 8).		6,920,562	9.00
10.00	Deductibles		17,172	10.00
11.00	Subtotal (line 9 minus line 10)		6,903,390	11.00
12.00	Coinsurance		203,045	12.00
13.00	Subtotal (line 11 minus line 12)		6,700,345	13.00
14.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		106,588	14.00
15.00	Adjusted reimbursable bad debts (see instructions)		74,612	15.00
16.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		105,456	16.00
17.00	Subtotal (sum of lines 13 and 15)		6,774,957	17.00
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)		0	18.00
19.00	Other pass through costs (see instructions)		0	19.00
20.00	Outlier payments reconciliation		0	20.00
21.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	21.00
21.99	Recovery of Accelerated Depreciation		0	21.99
22.00	Total amount payable to the provider (see instructions)		6,774,957	22.00
23.00	Interim payments		6,700,345	23.00
24.00	Tentative settlement (for contractor use only)		0	24.00
25.00	Balance due provider/program (line 22 minus the sum lines 23 and 24)		74,612	25.00
26.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		0	26.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from worksheet E-3, Part IV, line 2		0	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)		0	51.00
52.00	The rate used to calculate the Time Value of Money		0.00	52.00
53.00	Time Value of Money (see instructions)		0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 152021	Period: From 07/01/2011 To 06/30/2012	Worksheet E-3 Part VII Date/Time Prepared: 11/20/2012 4:58 pm
		Title XIX	Hospital	Cost
				1.00
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		576,871	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)		576,871	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)		576,871	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges		483,283	8.00
9.00	Ancillary service charges		927,580	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)		1,410,863	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)		1,410,863	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		833,992	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)		576,871	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.		576,871	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)		576,871	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)		576,871	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	37.00
38.00	Subtotal (line 36 ± line 37)		576,871	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)		576,871	40.00
41.00	Interim payments		576,871	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: 152021

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

Worksheet G

Date/Time Prepared:
11/20/2012 4:58 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	673,542	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	2,748,487	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-908,736	0	0	0	6.00
7.00	Inventory	142,004	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	7,378,184	2,789	0	0	9.00
10.00	Due from other funds	88,691	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	10,122,172	2,789	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	845,098	0	0	0	17.00
18.00	Accumulated depreciation	-831,127	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	1,101,877	0	0	0	23.00
24.00	Accumulated depreciation	-847,152	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)	268,696	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	24,890	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	24,890	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	10,415,758	2,789	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	234,229	0	0	0	37.00
38.00	Salaries, wages, and fees payable	444,456	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	0	0	0	0	43.00
44.00	Other current liabilities	1,322,901	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2,001,586	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	3,653	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	3,653	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	2,005,239	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	8,410,519	0	0	0	52.00
53.00	Specific purpose fund	0	2,789	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)	8,410,519	2,789	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	10,415,758	2,789	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 152021

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

Worksheet G-1

Date/Time Prepared:
11/20/2012 4:58 pm

	General Fund		Special Purpose Fund		
	1.00	2.00	3.00	4.00	
1.00 Fund balances at beginning of period		9,032,232		16,667	1.00
2.00 Net income (loss) (from wkst. G-3, line 29)		-640,821			2.00
3.00 Total (sum of line 1 and line 2)		8,391,411		16,667	3.00
4.00 DONATIONS	0		5,229		4.00
5.00 RELEASED OPERATING	19,107		0		5.00
6.00 ROUNDING	1		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)		19,108		5,229	10.00
11.00 Subtotal (line 3 plus line 10)		8,410,519		21,896	11.00
12.00 RELEASED CAPITAL	0		19,107		12.00
13.00	0		0		13.00
14.00	0		0		14.00
15.00	0		0		15.00
16.00	0		0		16.00
17.00	0		0		17.00
18.00 Total deductions (sum of lines 12-17)		0		19,107	18.00
19.00 Fund balance at end of period per balance sheet (line 11 minus line 18)		8,410,519		2,789	19.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 152021

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

Worksheet G-1

Date/Time Prepared:
11/20/2012 4:58 pm

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 152021

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
11/20/2012 4:58 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	10,358,971		10,358,971	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)	10,358,971		10,358,971	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)	10,358,971		10,358,971	17.00
18.00	Ancillary services	16,800,031	0	16,800,031	18.00
19.00	Outpatient services	0	0	0	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)	27,159,002	0	27,159,002	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per wkst. A, column 3, line 200)		11,162,450		29.00
30.00	BAD DEBTS	63,998			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)		63,998		36.00
37.00		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)		11,226,448		43.00

STATEMENT OF REVENUES AND EXPENSES		Provider CCN: 152021	Period: From 07/01/2011 To 06/30/2012	Worksheet G-3 Date/Time Prepared: 11/20/2012 4:58 pm
				1.00
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)			27,159,002 1.00
2.00	Less contractual allowances and discounts on patients' accounts			16,855,988 2.00
3.00	Net patient revenues (line 1 minus line 2)			10,303,014 3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)			11,226,448 4.00
5.00	Net income from service to patients (line 3 minus line 4)			-923,434 5.00
	OTHER INCOME			
6.00	Contributions, donations, bequests, etc			14,693 6.00
7.00	Income from investments			372,606 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			46 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			1,706 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			0 22.00
23.00	Governmental appropriations			0 23.00
24.00	MAINTENANCE REV			600 24.00
24.01	NON CASH FUNDED PENSION CURTAILMENT			432,944 24.01
25.00	Total other income (sum of lines 6-24)			822,595 25.00
26.00	Total (line 5 plus line 25)			-100,839 26.00
27.00	OTHER - UNREALIZED LOSS			539,982 27.00
28.00	Total other expenses (sum of line 27 and subscripts)			539,982 28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)			-640,821 29.00