

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: 150010	Period: From 07/01/2011 To 06/30/2012	Worksheet S Parts I-III Date/Time Prepared: 11/28/2012 1:32 pm
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<b>PART I - COST REPORT STATUS</b>			
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 type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 11/28/2012	Time: 1:32 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. JOSEPH HOSPITAL & HEALTH CENTR 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.

(Signed) \_\_\_\_\_  
 Officer or Administrator of Provider(s)

\_\_\_\_\_  
 Title

\_\_\_\_\_  
 Date

Cost Center Description	Title XVIII			HIT	Title XIX	
	Title V	Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	-309,863	186,775	0	0	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	-59,478	0	0	0	3.00
4.00 SUBPROVIDER I	0	0	0	0	0	4.00
5.00 Swing bed - SNF	0	0	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
7.00 SKILLED NURSING FACILITY	0	0	0	0	0	7.00
8.00 NURSING FACILITY	0	0	0	0	0	8.00
9.00 HOME HEALTH AGENCY I	0	0	0	0	0	9.00
10.00 RURAL HEALTH CLINIC I	0	0	0	0	0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0	0	0	0	0	11.00
12.00 CMHC I	0	0	0	0	0	12.00
200.00 Total	0	-369,341	186,775	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: 150010		Period: From 07/01/2011 To 06/30/2012		Worksheet S-2 Part I Date/Time Prepared: 11/28/2012 1:28 pm					
1.00		2.00		3.00		4.00							
Hospital and Hospital Health Care Complex Address:													
1.00	Street: 1907 WEST SYCAMORE			PO Box:				1.00					
2.00	City: KOKOMO			State: IN		Zip Code: 46901-		County: HOWARD					
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)					
		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. JOSEPH HOSPITAL & HEALTH CENTR		150010	29020	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF												4.00
5.00	Subprovider - IRF			ST. JOSEPH ACUTE REHAB UNIT		15T010	29020	5	07/01/2002	N	P	O	5.00
6.00	Subprovider - (Other)												6.00
7.00	Swing Beds - SNF									N	N	N	7.00
8.00	Swing Beds - NF									N		N	8.00
9.00	Hospital-Based SNF												9.00
10.00	Hospital-Based NF												10.00
11.00	Hospital-Based OLTC												11.00
12.00	Hospital-Based HHA												12.00
13.00	Separately Certified ASC												13.00
14.00	Hospital-Based Hospice												14.00
15.00	Hospital-Based Health Clinic - RHC												15.00
16.00	Hospital-Based Health Clinic - FQHC												16.00
17.00	Hospital-Based (CMHC) 1												17.00
18.00	Renal Dialysis												18.00
19.00	Other												19.00
							From:		To:				
							1.00		2.00				
20.00	Cost Reporting Period (mm/dd/yyyy)						07/01/2011		06/30/2012		20.00		
21.00	Type of Control (see instructions)								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.						Y		N		22.00		
23.00	Indicate in column 1 the method used to capture Medicaid (title XIX) days reported on lines 24 and/or 25 of this worksheet during the cost reporting period by entering a "1" if days are based on the date of admission, "2" if days are based on census days (also referred to as the day count), or "3" if the days are based on the date of discharge. Is the method of identifying the days in the current cost reporting period different from the method used in the prior cost reporting period? Enter in column 2 "Y" for yes or "N" for no.						3		N		23.00		
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible days	Medicaid HMO days	Other Medicaid days				
				1.00	2.00	3.00	4.00	5.00	6.00				
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			1,505	1,945	0	7	1,380	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.			118	62	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		

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		Beginning:	Ending:			
		1.00	2.00			
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.				38.00	
		V	XVIII	XIX		
		1.00	2.00	3.00		
<b>Prospective Payment System (PPS)-Capital</b>						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	Y	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	
<b>Teaching Hospitals</b>						
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)	Y			60.00	
		Y/N	IME Average	Direct GME Average		
		1.00	2.00	3.00		
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)	N	0.00	0.00	61.00	
<b>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</b>						
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	
<b>Teaching Hospitals that Claim Residents in Non-Provider Settings</b>						
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)	N			63.00	
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
		1.00	2.00	3.00		
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. If line 63 is yes or your facility trained residents in the base year period, enter in column 1, from your cost reporting period that begins on or after July 1, 2009, and before June 30, 2010 the number of unweighted nonprimary care FTE residents attributable to rotations that occurred in all nonprovider settings. Enter in column 2 the number of unweighted nonprimary care FTE residents that trained in your hospital. Include unweighted OB/GYN, dental and podiatry FTEs on this line. Enter in column 3, the ratio of column 1 divided by the sum of columns 1 and 2.	0.00	0.00	0.000000	64.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))
		1.00	2.00	3.00	4.00	5.00

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	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		

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	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
1.00 2.00 3.00							
<b>Inpatient Psychiatric Facility PPS</b>							
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N			70.00
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)				0		71.00
<b>Inpatient Rehabilitation Facility PPS</b>							
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.			Y			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)			N	N	0	76.00
1.00							
<b>Long Term Care Hospital PPS</b>							
80.00	Are you a long term care hospital (LTCH)? Enter in column 1 "Y" for yes and "N" for no. LTCHs can only exist as independent/freestanding facilities. An independent or freestanding facility may exist as an unrelated hospital within a hospital, it must meet the separateness (from the host/co-located provider) requirements identified in 42 CFR 412.22(e.)				N		80.00
<b>TEFRA Providers</b>							
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							
<b>Title V or XIX Inpatient Services</b>							
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N	Y		90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	N		91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.				N		92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	N		93.00

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		V	XIX					
		1.00	2.00					
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		
<b>Rural Providers</b>								
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		
<b>Miscellaneous Cost Reporting Information</b>								
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		
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.	181,565	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		
<b>DO NOT USE THIS LINE</b>								
119.00	DO NOT USE THIS LINE						119.00	
120.00	If this is an SCH (or EACH), regardless of bed size, or is rural hospital with 100 or fewer beds that qualifies for the outpatient hold harmless provision in accordance with ACA, section 3121, as amended by the Medicare and Medicaid Extenders Act (MMEA) of 2010, section 108; the Temporary Payroll Tax Cut Continuation Act of 2011, section 308; and the Middle Class Tax Relief and Job Creation Act of 2012, section 3002, enter "Y" for yes or "N" for no in column 1 or column 2, respectively. Note that for SCHs (and EACHs) the outpatient hold harmless provision is effective for services rendered from January 1, 2010 through February 29, 2012 regardless of bed size and from March 1, 2012 through December 31, 2012 to all SCHs (and EACHs) with 100 or fewer beds. These responses impact the TOPs calculation on Worksheet E, Part B, line 8.		N	N		120.00		
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.		Y			121.00		
<b>Transplant Center Information</b>								
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	

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		1.00	2.00				
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 STREET	PO Box:				142.00	
143.00	City: INDIANAPOLIS	State: IN		Zip Code: 46290		143.00	
				1.00			
144.00	Are provider based physicians' costs included in Worksheet A?			Y		144.00	
145.00	If costs for renal services are claimed on Worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.			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	
		Part A		Part B		Title V	
		1.00		2.00		3.00	
						Title XIX	
						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	
156.00	Subprovider - IPF	N		N		N	
157.00	Subprovider - IRF	N		N		N	
158.00	SUBPROVIDER	N		N		N	
159.00	SNF	N		N		N	
160.00	HOME HEALTH AGENCY	N		N		N	
161.00	CMHC	N		N		N	
						1.00	
165.00	Multi campus Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.			N		165.00	
		Name		County		State	
		0		1.00		2.00	
						3.00	
						4.00	
						5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5					0.00	
						1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.			N		167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)					0	
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	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 150010	Period: From 07/01/2011 To 06/30/2012	Worksheet S-2 Part II Date/Time Prepared: 11/28/2012 1:28 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)	Y			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	09/11/2012	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.	Y			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.	Y			8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N			9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
		Y/N			
		1.00			
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			Y	15.00
		Part A			
		Description	Y/N	Date	
		0	1.00	2.00	
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	10/10/2012		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N			19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N			20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 150010	Period: From 07/01/2011 To 06/30/2012	Worksheet S-2 Part II Date/Time Prepared: 11/28/2012 1:28 pm
		Part A		
Description		Y/N	Date	
0		1.00	2.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		21.00
				1.00
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>				
<b>Capital Related Cost</b>				
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions			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.			23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			27.00
<b>Interest Expense</b>				
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			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			29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			31.00
<b>Purchased Services</b>				
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			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.			33.00
<b>Provider-Based Physicians</b>				
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			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.			35.00
		Y/N	Date	
		1.00	2.00	
<b>Home Office Costs</b>				
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	
<b>Cost Report Preparer Contact Information</b>				
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	
<b>PS&amp;R Data</b>				
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		
<b>Cost Report Preparer Contact Information</b>				
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: 150010

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
11/28/2012 1:28 pm

Cost Center	Description	Worksheet A	No. of Beds	Bed Days	CAH Hours	
		Line Number		Avai lable		
		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	139	50,874	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)		139	50,874	0.00	7.00
8.00	INTENSIVE CARE UNIT	31.00	10	3,660	0.00	8.00
9.00	CORONARY CARE UNIT					9.00
10.00	BURN INTENSIVE CARE UNIT					10.00
11.00	SURGICAL INTENSIVE CARE UNIT					11.00
12.00	OTHER SPECIAL CARE (SPECIFY)					12.00
13.00	NURSERY	43.00				13.00
14.00	Total (see instructions)		149	54,534	0.00	14.00
15.00	CAH visits					15.00
16.00	SUBPROVIDER - IPF					16.00
17.00	SUBPROVIDER - IRF	41.00	18	6,588		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)		167			27.00
28.00	Observation Bed Days					28.00
28.02	SUBPROVIDER - IRF	41.00				28.02
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: 150010

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
11/28/2012 1:28 pm

Cost Center Description	I/P Days / O/P Visits / Trips				Total All Patients	
	Title V	Title XVIII	Title XIX			
	5.00	6.00	7.00	8.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	0	8,230	997	18,512	1.00	
2.00 HMO		727	2,224		2.00	
3.00 HMO IPF		0	0		3.00	
4.00 HMO IRF		190	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	6.00	
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	0	8,230	997	18,512	7.00	
8.00 INTENSIVE CARE UNIT	0	1,429	0	2,252	8.00	
9.00 CORONARY CARE UNIT					9.00	
10.00 BURN INTENSIVE CARE UNIT					10.00	
11.00 SURGICAL INTENSIVE CARE UNIT					11.00	
12.00 OTHER SPECIAL CARE (SPECIFY)					12.00	
13.00 NURSERY	0		1,383	1,403	13.00	
14.00 Total (see instructions)	0	9,659	2,380	22,167	14.00	
15.00 CAH visits	0	0	0	0	15.00	
16.00 SUBPROVIDER - IPF					16.00	
17.00 SUBPROVIDER - IRF	0	3,326	180	4,327	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		39	1,448	28.00	
28.02 SUBPROVIDER - IRF				0	28.02	
29.00 Ambulance Trips		2,005			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)			233	411	32.00	
33.00 LTCH non-covered days		0			33.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150010

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
11/28/2012 1:28 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	1,991	1.00
2.00 HMO					161	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	773.59	0.00	0	1,991	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0.00	27.71	0.00	0	236	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	801.30	0.00			27.00
28.00 Observation Bed Days						28.00
28.02 SUBPROVIDER - IRF						28.02
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: 150010

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
11/28/2012 1:28 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)	875	5,091		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)	875	5,091		14.00
15.00 CAH visits				15.00
16.00 SUBPROVIDER - IPF				16.00
17.00 SUBPROVIDER - IRF	35	301		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
28.02 SUBPROVIDER - IRF				28.02
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 WAGE INDEX INFORMATION

Provider CCN: 150010

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

Worksheet S-3  
Part II  
Date/Time Prepared:  
11/28/2012 1:28 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cat ion of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	
	1.00	2.00	3.00	4.00	5.00	
<b>PART II - WAGE DATA</b>						
<b>SALARIES</b>						
1.00	Total salaries (see instructions)	200.00	42,819,882	0	42,819,882	1,742,149.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00
5.00	Physician-Part B		0	0	0	0.00
6.00	Non-physician-Part B		0	0	0	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00
8.00	Home office personnel		0	0	0	0.00
9.00	SNF	44.00	0	0	0	0.00
10.00	Excluded area salaries (see instructions)		2,380,638	57,209	2,437,847	123,304.00
<b>OTHER WAGES &amp; RELATED COSTS</b>						
11.00	Contract labor (see instructions)		584,844	0	584,844	14,721.69
12.00	Contract management and administrative services		0	0	0	0.00
13.00	Contract labor: Physician-Part A - Administrative		239,000	0	239,000	780.00
14.00	Home office salaries & wage-related costs		3,909,495	0	3,909,495	56,426.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00
16.00	Home office and Contract Physicians Part A - Administrative		0	0	0	0.00
<b>WAGE-RELATED COSTS</b>						
17.00	Wage-related costs (core) Wkst S-3, Part IV Line 24		10,943,564	0	10,943,564	
18.00	Wage-related costs (other) Wkst S-3, Part IV Line 25		0	0	0	
19.00	Excluded areas		644,242	0	644,242	
20.00	Non-physician anesthetist Part A		0	0	0	
21.00	Non-physician anesthetist Part B		0	0	0	
22.00	Physician Part A - Administrative		0	0	0	
22.01	Physician Part A - Teaching		0	0	0	
23.00	Physician Part B		0	0	0	
24.00	Wage-related costs (RHC/FQHC)		0	0	0	
25.00	Interns & residents (in an approved program)		0	0	0	
<b>OVERHEAD COSTS - DIRECT SALARIES</b>						
26.00	Employee Benefits	4.00	1,877,458	0	1,877,458	75,665.00
27.00	Administrative & General	5.00	7,273,646	0	7,273,646	254,092.00
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00
30.00	Operation of Plant	7.00	905,098	0	905,098	46,380.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00
32.00	Housekeeping	9.00	776,359	0	776,359	61,801.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00
34.00	Dietary	10.00	801,833	-606,698	195,135	14,317.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00
36.00	Cafeteria	11.00	0	606,698	606,698	44,512.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00
38.00	Nursing Administration	13.00	352,222	0	352,222	10,500.00
39.00	Central Services and Supply	14.00	0	0	0	0.00
40.00	Pharmacy	15.00	1,178,934	0	1,178,934	32,584.00
41.00	Medical Records & Medical Records Library	16.00	880,470	0	880,470	50,268.00
42.00	Social Service	17.00	375,545	0	375,545	14,899.00
43.00	Other General Service	18.00	0	0	0	0.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150010

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

Worksheet S-3  
Part II  
Date/Time Prepared:  
11/28/2012 1:28 pm

		Average Hourly Wage (col. 4 + col. 5)	
		6.00	
<b>PART II - WAGE DATA</b>			
<b>SALARIES</b>			
1.00	Total salaries (see instructions)	24.58	1.00
2.00	Non-physician anesthetist Part A	0.00	2.00
3.00	Non-physician anesthetist Part B	0.00	3.00
4.00	Physician-Part A - Administrative	0.00	4.00
4.01	Physicians - Part A - Teaching	0.00	4.01
5.00	Physician-Part B	0.00	5.00
6.00	Non-physician-Part B	0.00	6.00
7.00	Interns & residents (in an approved program)	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)	0.00	7.01
8.00	Home office personnel	0.00	8.00
9.00	SNF	0.00	9.00
10.00	Excluded area salaries (see instructions)	19.77	10.00
<b>OTHER WAGES &amp; RELATED COSTS</b>			
11.00	Contract labor (see instructions)	39.73	11.00
12.00	Contract management and administrative services	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative	306.41	13.00
14.00	Home office salaries & wage-related costs	69.29	14.00
15.00	Home office: Physician Part A - Administrative	0.00	15.00
16.00	Home office and Contract Physicians Part A - Administrative	0.00	16.00
<b>WAGE-RELATED COSTS</b>			
17.00	Wage-related costs (core) Wkst S-3, Part IV Line 24		17.00
18.00	Wage-related costs (other)Wkst S-3, Part IV Line 25		18.00
19.00	Excluded areas		19.00
20.00	Non-physician anesthetist Part A		20.00
21.00	Non-physician anesthetist Part B		21.00
22.00	Physician Part A - Administrative		22.00
22.01	Physician Part A - Teaching		22.01
23.00	Physician Part B		23.00
24.00	Wage-related costs (RHC/FOHC)		24.00
25.00	Interns & residents (in an approved program)		25.00
<b>OVERHEAD COSTS - DIRECT SALARIES</b>			
26.00	Employee Benefits	24.81	26.00
27.00	Administrative & General	28.63	27.00
28.00	Administrative & General under contract (see inst.)	0.00	28.00
29.00	Maintenance & Repairs	0.00	29.00
30.00	Operation of Plant	19.51	30.00
31.00	Laundry & Linen Service	0.00	31.00
32.00	Housekeeping	12.56	32.00
33.00	Housekeeping under contract (see instructions)	0.00	33.00
34.00	Dietary	13.63	34.00
35.00	Dietary under contract (see instructions)	0.00	35.00
36.00	Cafeteria	13.63	36.00
37.00	Maintenance of Personnel	0.00	37.00
38.00	Nursing Administration	33.54	38.00
39.00	Central Services and Supply	0.00	39.00
40.00	Pharmacy	36.18	40.00
41.00	Medical Records & Medical Records Library	17.52	41.00
42.00	Social Service	25.21	42.00
43.00	Other General Service	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION		Provider CCN: 150010		Period: From 07/01/2011 To 06/30/2012		Worksheet S-3 Part III Date/Time Prepared: 11/28/2012 1:28 pm	
	Worksheet A Line Number	Amount Reported	Recl assi fi cat ion of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4		
	1.00	2.00	3.00	4.00	5.00		
<b>PART III - HOSPITAL WAGE INDEX SUMMARY</b>							
1.00	Net salaries (see instructions)	42,819,882	0	42,819,882	1,742,149.00		1.00
2.00	Excluded area salaries (see instructions)	2,380,638	57,209	2,437,847	123,304.00		2.00
3.00	Subtotal salaries (line 1 minus line 2)	40,439,244	-57,209	40,382,035	1,618,845.00		3.00
4.00	Subtotal other wages & related costs (see inst.)	4,733,339	0	4,733,339	71,927.69		4.00
5.00	Subtotal wage-related costs (see inst.)	10,943,564	0	10,943,564	0.00		5.00
6.00	Total (sum of lines 3 thru 5)	56,116,147	-57,209	56,058,938	1,690,772.69		6.00
7.00	Total overhead cost (see instructions)	14,421,565	0	14,421,565	605,018.00		7.00

HOSPITAL WAGE INDEX INFORMATION		Provider CCN: 150010	Period: From 07/01/2011 To 06/30/2012	Worksheet S-3 Part III Date/Time Prepared: 11/28/2012 1:28 pm
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		Average Hourly Wage (col. 4 ÷ col. 5)	
		6.00	
<b>PART III - HOSPITAL WAGE INDEX SUMMARY</b>			
1.00	Net salaries (see instructions)	24.58	1.00
2.00	Excluded area salaries (see instructions)	19.77	2.00
3.00	Subtotal salaries (line 1 minus line 2)	24.94	3.00
4.00	Subtotal other wages & related costs (see inst.)	65.81	4.00
5.00	Subtotal wage-related costs (see inst.)	27.10	5.00
6.00	Total (sum of lines 3 thru 5)	33.16	6.00
7.00	Total overhead cost (see instructions)	23.84	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 150010	Period: From 07/01/2011 To 06/30/2012	Worksheet S-3 Part IV Date/Time Prepared: 11/28/2012 1:28 pm
			Amount Reported	
			1.00	
<b>PART IV - WAGE RELATED COSTS</b>				
<b>Part A - Core List</b>				
<b>RETIREMENT COST</b>				
1.00	401K Employer Contributions		0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution		0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)		1,756,161	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)		0	4.00
<b>PLAN ADMINISTRATIVE COSTS (Paid to External Organization)</b>				
5.00	401K/TSA Plan Administration fees		0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan		0	6.00
7.00	Employee Managed Care Program Administration Fees		0	7.00
<b>HEALTH AND INSURANCE COST</b>				
8.00	Health Insurance (Purchased or Self Funded)		6,126,576	8.00
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		70,423	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		43,158	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)		0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)		248,191	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		268,951	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		0	16.00
<b>TAXES</b>				
17.00	FICA-Employers Portion Only		3,018,571	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		0	19.00
20.00	State or Federal Unemployment Taxes		34,020	20.00
<b>OTHER</b>				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))		21,756	21.00
22.00	Day Care Cost and Allowances		0	22.00
23.00	Tuition Reimbursement		0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		11,587,807	24.00
<b>Part B - Other than Core Related Cost</b>				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 150010	Period: From 07/01/2011 To 06/30/2012	Worksheet S-3 Part V Date/Time Prepared: 11/28/2012 1:28 pm
Cost Center Description			Contract Labor	Benefit Cost
PART V - Contract Labor and Benefit Cost			1.00	2.00
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost		0	0 1.00
2.00	Hospital		0	0 2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF		0	0 4.00
5.00	Subprovider - (Other)		0	0 5.00
6.00	Swing Beds - SNF		0	0 6.00
7.00	Swing Beds - NF		0	0 7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis		0	0 17.00
18.00	Other		0	0 18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 150010	Period: From 07/01/2011 To 06/30/2012	Worksheet S-10 Date/Time Prepared: 11/28/2012 1:28 pm
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			1.00		
<b>Uncompensated and indigent care cost computation</b>					
1.00	Cost to charge ratio (Worksheet C, Part I line 200 column 3 divided by line 200 column 8)		0.270243	1.00	
<b>Medicaid (see instructions for each line)</b>					
2.00	Net revenue from Medicaid		11,943,051	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?		N	3.00	
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?			4.00	
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		0	5.00	
6.00	Medicaid charges		42,726,961	6.00	
7.00	Medicaid cost (line 1 times line 6)		11,546,662	7.00	
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		0	8.00	
<b>State Children's Health Insurance Program (SCHIP) (see instructions for each line)</b>					
9.00	Net revenue from stand-alone SCHIP		0	9.00	
10.00	Stand-alone SCHIP charges		0	10.00	
11.00	Stand-alone SCHIP cost (line 1 times line 10)		0	11.00	
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00	
<b>Other state or local government indigent care program (see instructions for each line)</b>					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00	
<b>Uncompensated care (see instructions for each line)</b>					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations		13,735	18.00	
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		0	19.00	
			1.00		
			1.00		
			2.00		
			3.00		
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	6,819,866	0	6,819,866	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	1,843,021	0	1,843,021	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,843,021	0	1,843,021	23.00
			1.00		
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?				24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit			0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)			12,060,079	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)			213,790	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)			11,846,289	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)			3,201,377	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)			5,044,398	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			5,044,398	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES			Provider CCN: 150010		Period: From 07/01/2011 To 06/30/2012		Worksheet A	
Date/Time Prepared: 11/28/2012 1:28 pm								
Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00101	CAP REL COSTS-BLDG & FIXT		5,277,969	5,277,969	1,816,977	7,094,946	1.00
2.00	00201	CAP REL COSTS-MVBLE EQUIP		0	0	0	0	2.00
4.00	00400	EMPLOYEE BENEFITS	1,877,458	11,226,314	13,103,772	615,678	13,719,450	4.00
5.01	00510	NONPATIENT TELEPHONES	0	277,554	277,554	-204,502	73,052	5.01
5.02	00511	DATA PROCESSING	1,002	5,475	6,477	-1,610	4,867	5.02
5.03	00512	PURCHASING, RECEIVING AND STORES	324,743	257,280	582,023	-33,976	548,047	5.03
5.04	00513	ADMINISTRATIVE	1,025,349	122,458	1,147,807	-13,602	1,134,205	5.04
5.05	00514	CASHIERING/ACCOUNTS RECEIVABLE	608,548	1,089,980	1,698,528	-13,976	1,684,552	5.05
5.06	00560	OTHER ADMINISTRATIVE AND GENERAL	5,314,004	16,070,056	21,384,060	-814,323	20,569,737	5.06
7.00	00700	OPERATION OF PLANT	905,098	2,429,994	3,335,092	273,601	3,608,693	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	472,902	472,902	8.00
9.00	00900	HOUSEKEEPING	776,359	1,003,898	1,780,257	-408,058	1,372,199	9.00
10.00	01000	DIETARY	801,833	1,514,703	2,316,536	-1,754,283	562,253	10.00
11.00	01100	CAFETERIA	0	0	0	1,752,782	1,752,782	11.00
13.00	01300	NURSING ADMINISTRATION	352,222	71,969	424,191	-69,570	354,621	13.00
15.00	01500	PHARMACY	1,178,934	4,018,691	5,197,625	-204,042	4,993,583	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	880,470	77,329	957,799	-6,726	951,073	16.00
17.00	01700	SOCIAL SERVICE	375,545	43,410	418,955	-1,610	417,345	17.00
23.00	02301	ALLIED HEALTH	68,769	0	68,769	57,927	126,696	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	6,393,789	673,227	7,067,016	-337,785	6,729,231	30.00
31.00	03100	INTENSIVE CARE UNIT	1,452,760	278,701	1,731,461	-201,993	1,529,468	31.00
41.00	04100	SUBPROVIDER - IRF	1,266,939	164,397	1,431,336	-56,639	1,374,697	41.00
43.00	04300	NURSERY	0	0	0	478,700	478,700	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	3,475,580	6,475,376	9,950,956	-3,097,368	6,853,588	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,784,786	386,190	2,170,976	-631,586	1,539,390	52.00
53.00	05300	ANESTHESIOLOGY	0	72,937	72,937	-66,430	6,507	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,260,124	2,270,344	5,530,468	-386,108	5,144,360	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	144,927	368,645	513,572	-165,924	347,648	59.00
60.00	06000	LABORATORY	1,843,863	3,502,667	5,346,530	-109,031	5,237,499	60.00
65.00	06500	RESPIRATORY THERAPY	1,411,942	280,319	1,692,261	-42,992	1,649,269	65.00
66.00	06600	PHYSICAL THERAPY	2,735,790	576,435	3,312,225	-434,187	2,878,038	66.00
69.00	06900	ELECTROCARDIOLOGY	1,042,207	467,911	1,510,118	-142,519	1,367,599	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	343,744	1,604,938	1,948,682	1,353,979	3,302,661	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,176,225	3,176,225	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	288,831	288,831	73.00
74.00	07400	RENAL DIALYSIS	0	242,510	242,510	-7,913	234,597	74.00
76.00	03020	PSYCH SERVICES	5,230	161,902	167,132	-47,785	119,347	76.00
76.02	03022	ENDOSCOPY	349,961	231,925	581,886	-84,688	497,198	76.02
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	188,039	622,360	810,399	-67,696	742,703	90.00
91.00	09100	EMERGENCY	1,584,937	364,726	1,949,663	-173,535	1,776,128	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES	811,118	179,250	990,368	-32,303	958,065	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE		630,097	630,097	-630,097	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	42,586,070	63,041,937	105,628,007	44,745	105,672,752	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	-1,074	-1,074	192.00
194.00	07950	FOUNDATION	0	0	0	0	0	194.00
194.01	07951	CLINIC OF HOPE	233,812	90,256	324,068	-43,671	280,397	194.01
194.04	07952	COMMUNITY RELATIONS	0	239	239	0	239	194.04
200.00		TOTAL (SUM OF LINES 118-199)	42,819,882	63,132,432	105,952,314	0	105,952,314	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150010

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

Worksheet A  
Date/Time Prepared:  
11/28/2012 1:28 pm

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
		6.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	00101	875,506	7,970,452	1.00
2.00	00201	0	0	2.00
4.00	00400	-1,905,055	11,814,395	4.00
5.01	00510	88,072	161,124	5.01
5.02	00511	3,371,565	3,376,432	5.02
5.03	00512	128,883	676,930	5.03
5.04	00513	6,440	1,140,645	5.04
5.05	00514	12,078	1,696,630	5.05
5.06	00560	-7,268,013	13,301,724	5.06
7.00	00700	-5,683	3,603,010	7.00
8.00	00800	-50,510	422,392	8.00
9.00	00900	0	1,372,199	9.00
10.00	01000	-79,878	482,375	10.00
11.00	01100	-622,265	1,130,517	11.00
13.00	01300	0	354,621	13.00
15.00	01500	-39,760	4,953,823	15.00
16.00	01600	136,710	1,087,783	16.00
17.00	01700	0	417,345	17.00
23.00	02301	0	126,696	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000	-546,850	6,182,381	30.00
31.00	03100	-3,050	1,526,418	31.00
41.00	04100	-55,000	1,319,697	41.00
43.00	04300	0	478,700	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000	0	6,853,588	50.00
51.00	05100	0	0	51.00
52.00	05200	-338	1,539,052	52.00
53.00	05300	0	6,507	53.00
54.00	05400	-252,658	4,891,702	54.00
57.00	05700	0	0	57.00
58.00	05800	0	0	58.00
59.00	05900	0	347,648	59.00
60.00	06000	-93	5,237,406	60.00
65.00	06500	-3,050	1,646,219	65.00
66.00	06600	-66,581	2,811,457	66.00
69.00	06900	0	1,367,599	69.00
71.00	07100	0	3,302,661	71.00
72.00	07200	0	3,176,225	72.00
73.00	07300	0	288,831	73.00
74.00	07400	0	234,597	74.00
76.00	03020	-113,522	5,825	76.00
76.02	03022	0	497,198	76.02
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000	0	742,703	90.00
91.00	09100	0	1,776,128	91.00
92.00	09200	0	0	92.00
92.01	09201	0	0	92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00	09500	0	958,065	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
113.00	11300	0	0	113.00
118.00		-6,393,052	99,279,700	118.00
<b>NONREIMBURSABLE COST CENTERS</b>				
190.00	19000	0	0	190.00
192.00	19200	0	-1,074	192.00
194.00	07950	0	0	194.00
194.01	07951	0	280,397	194.01
194.04	07952	1,431,864	1,432,103	194.04
200.00		-4,961,188	100,991,126	200.00

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
<b>A - BENEFITS TRANSFER</b>					
1.00	EMPLOYEE BENEFITS	4.00	0	615,678	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
TOTALS			0	615,678	
<b>B - UTILITIES TRANSFER</b>					
1.00	OPERATION OF PLANT	7.00	0	275,350	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
TOTALS			0	275,350	
<b>C - PHARMACY - CHARGEABLE DRUGS</b>					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	288,831	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
TOTALS			0	288,831	
<b>D - BUILDING RENT</b>					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	479,928	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
TOTALS			0	479,928	
<b>E - RENT-LEASE EQUIPMENT</b>					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	544,050	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
29.00		0.00	0	0	29.00
30.00		0.00	0	0	30.00
<b>TOTALS</b>					
					544,050
<b>F - TAXES</b>					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	70,412	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
<b>TOTALS</b>					70,412
<b>G - LAUNDRY</b>					
1.00	LAUNDRY & LINEN SERVICE	8.00	0	472,902	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
<b>TOTALS</b>					472,902
<b>H - INSURANCE</b>					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	92,490	1.00
<b>TOTALS</b>					92,490
<b>I - NURSERY</b>					
1.00	NURSERY	43.00	373,028	105,672	1.00
<b>TOTALS</b>					373,028
<b>TOTALS</b>					105,672
<b>J - INTEREST</b>					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	558,622	1.00
<b>TOTALS</b>					558,622
<b>K - INTEREST - 2005 SERIES</b>					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	71,475	1.00
<b>TOTALS</b>					71,475
<b>L - MEDICAL SUPPLIES</b>					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	1,818,869	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
<b>TOTALS</b>					1,818,869
<b>N - CHARITABLE EXPENSES</b>					
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	6,957	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00

Provider CCN: 150010

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

Worksheet A-6  
Date/Time Prepared:  
11/28/2012 1:28 pm

		Increases				
		Cost Center	Line #	Salary	Other	
		2.00	3.00	4.00	5.00	
	TOTALS			0	6,957	
0 - DIETARY-CAFETERIA						
1.00	CAFETERIA		11.00	606,698	1,146,084	1.00
	TOTALS			606,698	1,146,084	
P - IMPLANTABLES						
1.00	IMPL. DEV. CHARGED TO		72.00	0	3,176,225	1.00
	PATIENTS					
2.00			0.00	0	0	2.00
3.00			0.00	0	0	3.00
4.00			0.00	0	0	4.00
	TOTALS			0	3,176,225	
Q - PARAMED						
1.00	ALLIED HEALTH		23.00	57,927	0	1.00
2.00			0.00	0	0	2.00
	TOTALS			57,927	0	
500.00	Grand Total: Increases			1,037,653	9,723,545	500.00

RECLASSIFICATIONS

Provider CCN: 150010

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

Worksheet A-6  
Date/Time Prepared:  
11/28/2012 1:28 pm

		Decreases				Wkst. A-7 Ref.	
Cost Center	Line #	Salary	Other				
6.00	7.00	8.00	9.00	10.00			
<b>A - BENEFITS TRANSFER</b>							
1.00	PURCHASING, RECEIVING AND STORES	5.03	0	46	0		1.00
2.00	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	613,991	0		2.00
3.00	OPERATING ROOM	50.00	0	61	0		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	320	0		4.00
5.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	1,260	0		5.00
	<b>TOTALS</b>		0	615,678			
<b>B - UTILITIES TRANSFER</b>							
1.00	NONPATIENT TELEPHONES	5.01	0	179,333	0		1.00
2.00	ADMINISTRATIVE	5.04	0	3,353	0		2.00
3.00	CASHIERING/ACCOUNTS RECEIVABLE	5.05	0	10,044	0		3.00
4.00	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	14,811	0		4.00
5.00	MEDICAL RECORDS & LIBRARY	16.00	0	2,355	0		5.00
6.00	INTENSIVE CARE UNIT	31.00	0	240	0		6.00
7.00	OPERATING ROOM	50.00	0	1,200	0		7.00
8.00	DELIVERY ROOM & LABOR ROOM	52.00	0	55	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	11,222	0		9.00
10.00	LABORATORY	60.00	0	613	0		10.00
11.00	RESPIRATORY THERAPY	65.00	0	240	0		11.00
12.00	PHYSICAL THERAPY	66.00	0	25,964	0		12.00
13.00	ELECTROCARDIOLOGY	69.00	0	952	0		13.00
14.00	EMERGENCY	91.00	0	12,581	0		14.00
15.00	CLINIC OF HOPE	194.01	0	12,387	0		15.00
	<b>TOTALS</b>		0	275,350			
<b>C - PHARMACY - CHARGEABLE DRUGS</b>							
1.00	PURCHASING, RECEIVING AND STORES	5.03	0	1,294	0		1.00
2.00	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	20,184	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	1,857	0		3.00
4.00	INTENSIVE CARE UNIT	31.00	0	372	0		4.00
5.00	SUBPROVIDER - IRF	41.00	0	150	0		5.00
6.00	OPERATING ROOM	50.00	0	1,892	0		6.00
7.00	DELIVERY ROOM & LABOR ROOM	52.00	0	2,880	0		7.00
8.00	ANESTHESIOLOGY	53.00	0	66,232	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	79,278	0		9.00
10.00	LABORATORY	60.00	0	157	0		10.00
11.00	RESPIRATORY THERAPY	65.00	0	1,291	0		11.00
12.00	PHYSICAL THERAPY	66.00	0	1,169	0		12.00
13.00	ELECTROCARDIOLOGY	69.00	0	75,475	0		13.00
14.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	1,801	0		14.00
15.00	RENAL DIALYSIS	74.00	0	454	0		15.00
16.00	CLINIC	90.00	0	13,512	0		16.00
17.00	EMERGENCY	91.00	0	4,066	0		17.00
18.00	AMBULANCE SERVICES	95.00	0	4,285	0		18.00
19.00	CLINIC OF HOPE	194.01	0	12,482	0		19.00
	<b>TOTALS</b>		0	288,831			
<b>D - BUILDING RENT</b>							
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	300	9		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	36,813	0		2.00
3.00	LABORATORY	60.00	0	5,282	0		3.00
4.00	PHYSICAL THERAPY	66.00	0	344,473	0		4.00
5.00	ELECTROCARDIOLOGY	69.00	0	30,285	0		5.00
6.00	PSYCH SERVICES	76.00	0	47,775	0		6.00
7.00	CLINIC OF HOPE	194.01	0	15,000	0		7.00
	<b>TOTALS</b>		0	479,928			
<b>E - RENT-LEASE EQUIPMENT</b>							
1.00	NONPATIENT TELEPHONES	5.01	0	25,169	9		1.00
2.00	DATA PROCESSING	5.02	0	1,610	0		2.00
3.00	PURCHASING, RECEIVING AND STORES	5.03	0	32,476	0		3.00
4.00	ADMINISTRATIVE	5.04	0	6,299	0		4.00
5.00	CASHIERING/ACCOUNTS RECEIVABLE	5.05	0	3,842	0		5.00
6.00	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	15,462	0		6.00
7.00	OPERATION OF PLANT	7.00	0	1,628	0		7.00

RECLASSIFICATIONS

Provider CCN: 150010

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

Worksheet A-6  
Date/Time Prepared:  
11/28/2012 1:28 pm

Decreases								
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.			
	6.00	7.00	8.00	9.00	10.00			
8.00	HOUSEKEEPING	9.00	0	625	0		8.00	
9.00	DIETARY	10.00	0	1,142	0		9.00	
10.00	NURSING ADMINISTRATION	13.00	0	66,525	0		10.00	
11.00	PHARMACY	15.00	0	198,115	0		11.00	
12.00	MEDICAL RECORDS & LIBRARY	16.00	0	4,368	0		12.00	
13.00	SOCIAL SERVICE	17.00	0	1,610	0		13.00	
14.00	ADULTS & PEDIATRICS	30.00	0	12,980	0		14.00	
15.00	INTENSIVE CARE UNIT	31.00	0	6,070	0		15.00	
16.00	SUBPROVIDER - IRF	41.00	0	1,610	0		16.00	
17.00	OPERATING ROOM	50.00	0	6,050	0		17.00	
18.00	DELIVERY ROOM & LABOR ROOM	52.00	0	2,860	0		18.00	
19.00	RADIOLOGY-DIAGNOSTIC	54.00	0	70,701	0		19.00	
20.00	LABORATORY	60.00	0	23,332	0		20.00	
21.00	RESPIRATORY THERAPY	65.00	0	20,740	0		21.00	
22.00	PHYSICAL THERAPY	66.00	0	13,012	0		22.00	
23.00	ELECTROCARDIOLOGY	69.00	0	2,593	0		23.00	
24.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	13,793	0		24.00	
25.00	PSYCH SERVICES	76.00	0	10	0		25.00	
26.00	CLINIC	90.00	0	625	0		26.00	
27.00	EMERGENCY	91.00	0	7,494	0		27.00	
28.00	AMBULANCE SERVICES	95.00	0	625	0		28.00	
29.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	1,074	0		29.00	
30.00	CLINIC OF HOPE	194.01	0	1,610	0		30.00	
	TOTALS		0	544,050				
F - TAXES								
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	62,826	9		1.00	
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	6,244	0		2.00	
3.00	LABORATORY	60.00	0	1,342	0		3.00	
	TOTALS		0	70,412				
G - LAUNDRY								
1.00	HOUSEKEEPING	9.00	0	405,266	0		1.00	
2.00	OPERATING ROOM	50.00	0	27,396	0		2.00	
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	3,034	0		3.00	
4.00	PHYSICAL THERAPY	66.00	0	24,886	0		4.00	
5.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	12,320	0		5.00	
	TOTALS		0	472,902				
H - INSURANCE								
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	92,490	9		1.00	
	TOTALS		0	92,490				
I - NURSERY								
1.00	DELIVERY ROOM & LABOR ROOM	52.00	373,028	105,672	0		1.00	
	TOTALS		373,028	105,672				
J - INTEREST								
1.00	INTEREST EXPENSE	113.00	0	558,622	9		1.00	
	TOTALS		0	558,622				
K - INTEREST - 2005 SERIES								
1.00	INTEREST EXPENSE	113.00	0	71,475	9		1.00	
	TOTALS		0	71,475				
L - MEDICAL SUPPLIES								
1.00	PURCHASING, RECEIVING AND STORES	5.03	0	16	0		1.00	
2.00	ADMINISTRATIVE	5.04	0	3,950	0		2.00	
3.00	CASHIERING/ACCOUNTS RECEIVABLE	5.05	0	90	0		3.00	
4.00	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	1,216	0		4.00	
5.00	OPERATION OF PLANT	7.00	0	121	0		5.00	
6.00	HOUSEKEEPING	9.00	0	2,167	0		6.00	
7.00	DIETARY	10.00	0	279	0		7.00	
8.00	NURSING ADMINISTRATION	13.00	0	3,045	0		8.00	
9.00	PHARMACY	15.00	0	5,927	0		9.00	
10.00	MEDICAL RECORDS & LIBRARY	16.00	0	3	0		10.00	
11.00	ADULTS & PEDIATRICS	30.00	0	322,948	0		11.00	
12.00	INTENSIVE CARE UNIT	31.00	0	195,311	0		12.00	
13.00	SUBPROVIDER - IRF	41.00	0	54,161	0		13.00	
14.00	OPERATING ROOM	50.00	0	354,611	0		14.00	
15.00	DELIVERY ROOM & LABOR ROOM	52.00	0	147,091	0		15.00	
16.00	ANESTHESIOLOGY	53.00	0	198	0		16.00	
17.00	RADIOLOGY-DIAGNOSTIC	54.00	0	120,442	0		17.00	
18.00	CARDIAC CATHETERIZATION	59.00	0	142,171	0		18.00	

Decreases								
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.			
	6.00	7.00	8.00	9.00	10.00			
19.00	LABORATORY	60.00	0	74,302	0		19.00	
20.00	RESPIRATORY THERAPY	65.00	0	20,721	0		20.00	
21.00	PHYSICAL THERAPY	66.00	0	24,683	0		21.00	
22.00	ELECTROCARDIOLOGY	69.00	0	33,214	0		22.00	
23.00	RENAL DIALYSIS	74.00	0	7,459	0		23.00	
24.00	ENDOSCOPY	76.02	0	84,688	0		24.00	
25.00	CLINIC	90.00	0	42,961	0		25.00	
26.00	EMERGENCY	91.00	0	149,394	0		26.00	
27.00	AMBULANCE SERVICES	95.00	0	27,393	0		27.00	
28.00	CLINIC OF HOPE	194.01	0	307	0		28.00	
	TOTALS		0	1,818,869				
<b>N - CHARITABLE EXPENSES</b>								
1.00	PURCHASING, RECEIVING AND STORES	5.03	0	144	0		1.00	
2.00	DIETARY	10.00	0	80	0		2.00	
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	845	0		3.00	
4.00	LABORATORY	60.00	0	4,003	0		4.00	
5.00	CLINIC OF HOPE	194.01	0	1,885	0		5.00	
	TOTALS		0	6,957				
<b>Q - DIETARY-CAFETERIA</b>								
1.00	DIETARY	10.00	606,698	1,146,084	0		1.00	
	TOTALS		606,698	1,146,084				
<b>P - IMPLANTABLES</b>								
1.00	OPERATING ROOM	50.00	0	2,706,158	0		1.00	
2.00	CARDIAC CATHETERIZATION	59.00	0	23,753	0		2.00	
3.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	435,716	0		3.00	
4.00	CLINIC	90.00	0	10,598	0		4.00	
	TOTALS		0	3,176,225				
<b>Q - PARAMED</b>								
1.00	RADIOLOGY-DIAGNOSTIC	54.00	57,209	0	0		1.00	
2.00	SUBPROVIDER - IRF	41.00	718	0	0		2.00	
	TOTALS		57,927	0				
500.00	Grand Total: Decreases		1,037,653	9,723,545			500.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150010

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

Worksheet A-7  
Parts I-III  
Date/Time Prepared:  
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		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	1,422,671	0	0	0	0	1.00
2.00	Land Improvements	2,340,617	8,044	0	8,044	54,739	2.00
3.00	Buildings and Fixtures	56,096,317	0	0	0	171,502	3.00
4.00	Building Improvements	8,882,768	15,000	0	15,000	2,925	4.00
5.00	Fixed Equipment	24,284,690	435,146	0	435,146	831,282	5.00
6.00	Movable Equipment	49,935,203	2,921,877	0	2,921,877	7,569,546	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	142,962,266	3,380,067	0	3,380,067	8,629,994	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	142,962,266	3,380,067	0	3,380,067	8,629,994	10.00
<b>SUMMARY OF CAPITAL</b>							
Cost Center Description		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
<b>PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2</b>							
1.00	CAP REL COSTS-BLDG & FIXT	5,202,194	3,025	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	5,202,194	3,025	0	0	0	3.00
<b>COMPUTATION OF RATIOS</b>							
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	
<b>PART III - RECONCILIATION OF CAPITAL COSTS CENTERS</b>							
1.00	CAP REL COSTS-BLDG & FIXT	303,705,221	0	303,705,221	0.870234	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	45,287,534	0	45,287,534	0.129766	0	2.00
3.00	Total (sum of lines 1-2)	348,992,755	0	348,992,755	1.000000	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150010

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

Worksheet A-7  
Parts I-III  
Date/Time Prepared:  
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		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	1,422,671	0		1.00		
2.00	Land Improvements	2,293,922	0		2.00		
3.00	Buildings and Fixtures	55,924,815	0		3.00		
4.00	Building Improvements	8,894,843	0		4.00		
5.00	Fixed Equipment	23,888,554	0		5.00		
6.00	Movable Equipment	45,287,534	0		6.00		
7.00	HIT designated Assets	0	0		7.00		
8.00	Subtotal (sum of lines 1-7)	137,712,339	0		8.00		
9.00	Reconciling Items	0	0		9.00		
10.00	Total (line 8 minus line 9)	137,712,339	0		10.00		
<b>SUMMARY OF CAPITAL</b>							
Cost Center Description		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
<b>PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2</b>							
1.00	CAP REL COSTS-BLDG & FIXT	72,750	5,277,969		1.00		
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		2.00		
3.00	Total (sum of lines 1-2)	72,750	5,277,969		3.00		
<b>ALLOCATION OF OTHER CAPITAL</b>							
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	
<b>PART III - RECONCILIATION OF CAPITAL COSTS CENTERS</b>							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	7,894,677	3,025	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	7,894,677	3,025	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150010

Period:  
From 07/01/2011  
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Worksheet A-7  
Parts I-III  
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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	0	0	0	72,750	7,970,452	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	72,750	7,970,452	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 150010

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

Worksheet A-8

Date/Time Prepared:  
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Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
			Cost Center		Line #	
			1.00	2.00	3.00	4.00
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	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)		0	0		0.00	3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0	0		0.00	4.00
5.00 Refunds and rebates of expenses (chapter 8)		0	0		0.00	5.00
6.00 Rental of provider space by suppliers (chapter 8)		0	0		0.00	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)	B	-27,410	0	NONPATIENT TELEPHONES	5.01	7.00
8.00 Television and radio service (chapter 21)	A	-3,048	0	OPERATION OF PLANT	7.00	8.00
9.00 Parking lot (chapter 21)		0	0		0.00	9.00
10.00 Provider-based physician adjustment	A-8-2	-1,673,989	0			10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0	0		0.00	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	-1,605,016	0			12.00
13.00 Laundry and linen service		0	0		0.00	13.00
14.00 Cafeteria-employees and guests	B	-615,306	0	CAFETERIA	11.00	14.00
15.00 Rental of quarters to employee and others		0	0		0.00	15.00
16.00 Sale of medical and surgical supplies to other than patients		0	0		0.00	16.00
17.00 Sale of drugs to other than patients		0	0		0.00	17.00
18.00 Sale of medical records and abstracts		0	0		0.00	18.00
19.00 Nursing school (tuition, fees, books, etc.)		0	0		0.00	19.00
20.00 Vending machines		0	0		0.00	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0	0		0.00	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0	0		0.00	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	0	RESPIRATORY THERAPY	65.00	23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	0	PHYSICAL THERAPY	66.00	24.00
25.00 Utilization review - physicians' compensation (chapter 21)		0	0	*** Cost Center Deleted ***	114.00	25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT		0	0	CAP REL COSTS-BLDG & FIXT	1.00	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP		0	0	CAP REL COSTS-MVBLE EQUIP	2.00	27.00
28.00 Non-physician Anesthetist		0	0	*** Cost Center Deleted ***	19.00	28.00
29.00 Physicians' assistant		0	0		0.00	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	0	*** Cost Center Deleted ***	67.00	30.00
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	0	*** Cost Center Deleted ***	68.00	31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0	0		0.00	32.00
33.00 SOUTHWAY REHAB OTH OP REV	B	-9,042	0	PHYSICAL THERAPY	66.00	33.00
34.00 FOREST PARK REHAB OTH OP REV	B	-43,539	0	PHYSICAL THERAPY	66.00	34.00
35.00 INFORMATION SERVICES OTHER OP REV	B	-8,310	0	DATA PROCESSING	5.02	35.00
36.00		0	0		0.00	36.00
37.00 ORGANIZATIONAL LEARNING OTHER OP REV	B	-3,681	0	OTHER ADMINISTRATIVE AND GENERAL	5.06	37.00
38.00 RENTAL INCOME	B	-479,928	0	CAP REL COSTS-BLDG & FIXT	1.00	38.00
39.00 INCENTIVE OVER-ACCRUAL	A	-183,908	0	OTHER ADMINISTRATIVE AND GENERAL	5.06	39.00
41.00 PLANT OPERATIONS OTHER OP REV	B	-2,635	0	OPERATION OF PLANT	7.00	41.00
42.00 PATIENT TELEVISION	A	-7,198	0	OTHER ADMINISTRATIVE AND GENERAL	5.06	42.00
43.00 FOOD SERVICES OTHER OP REV	B	-79,878	0	DIETARY	10.00	43.00
44.00 TRINITY OTHER OP REV	B	-7,006	0	ADULTS & PEDIATRICS	30.00	44.00
44.01		0	0		0.00	44.01
44.02		0	0		0.00	44.02
45.00		0	0		0.00	45.00
45.02 1994 AHA LIVES	A	12,652	0	CAP REL COSTS-BLDG & FIXT	1.00	45.02
45.05 RADIATION OTHER OP REV	B	-109,910	0	RADIOLOGY-DIAGNOSTIC	54.00	45.05

Provider CCN: 150010      Period: From 07/01/2011 To 06/30/2012      Worksheet A-8  
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Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Line #
			Cost Center		
			1.00	2.00	
45.08 LABORATORY OTHER OP REV	B	-93	LABORATORY	60.00	45.08
45.12 LOBBY EXPENSE	A	-1,317	OTHER ADMINISTRATIVE AND GENERAL	5.06	45.12
45.13 LABOR & DELIVERY OTHER OP REV	B	-338	DELIVERY ROOM & LABOR ROOM	52.00	45.13
45.15 SYCAMORE PRIMARY CARE OTHER OP REV	B	-4,893	OTHER ADMINISTRATIVE AND GENERAL	5.06	45.15
45.18 PHARMACY NON-PATIENT SALES	B	-39,760	PHARMACY	15.00	45.18
45.19 WOMENS HEALTH OTHER OP REV	B	-24,443	RADIOLOGY-DIAGNOSTIC	54.00	45.19
45.20 SYCAMORE PRIMARY CARE	B	-12,341	CAP REL COSTS-BLDG & FIXT	1.00	45.20
45.23 CAFETERIA/VENDING REVENUE	B	-6,959	CAFETERIA	11.00	45.23
45.24 ASPR BIOTERRORISM	B	-23,892	OTHER ADMINISTRATIVE AND GENERAL	5.06	45.24
45.25		0		0.00	45.25
45.26		0		0.00	45.26
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-4,961,188			50.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 150010

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

Worksheet A-8

Date/Time Prepared:  
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Cost Center Description		Wkst. A-7 Ref.		
		5.00		
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	0		1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	0		2.00
3.00	Investment income - other (chapter 2)	0		3.00
4.00	Trade, quantity, and time discounts (chapter 8)	0		4.00
5.00	Refunds and rebates of expenses (chapter 8)	0		5.00
6.00	Rental of provider space by suppliers (chapter 8)	0		6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	0		7.00
8.00	Television and radio service (chapter 21)	0		8.00
9.00	Parking lot (chapter 21)	0		9.00
10.00	Provider-based physician adjustment	0		10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	0		11.00
12.00	Related organization transactions (chapter 10)	0		12.00
13.00	Laundry and linen service	0		13.00
14.00	Cafeteria-employees and guests	0		14.00
15.00	Rental of quarters to employee and others	0		15.00
16.00	Sale of medical and surgical supplies to other than patients	0		16.00
17.00	Sale of drugs to other than patients	0		17.00
18.00	Sale of medical records and abstracts	0		18.00
19.00	Nursing school (tuition, fees, books, etc.)	0		19.00
20.00	Vending machines	0		20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)	0		21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments	0		22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)			23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)			24.00
25.00	Utilization review - physicians' compensation (chapter 21)			25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	0		26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	0		27.00
28.00	Non-physician Anesthetist			28.00
29.00	Physicians' assistant	0		29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)			30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)			31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	0		32.00
33.00	SOUTHWAY REHAB OTH OP REV	0		33.00
34.00	FOREST PARK REHAB OTH OP REV	0		34.00
35.00	INFORMATION SERVICES OTHER OP REV	0		35.00
36.00		0		36.00
37.00	ORGANIZATIONAL LEARNING OTHER OP REV	0		37.00
38.00	RENTAL INCOME	9		38.00
39.00	INCENTIVE OVER-ACCRUAL	0		39.00
41.00	PLANT OPERATIONS OTHER OP REV	0		41.00
42.00	PATIENT TELEVISION	0		42.00
43.00	FOOD SERVICES OTHER OP REV	0		43.00
44.00	TRINITY OTHER OP REV	0		44.00
44.01		0		44.01
44.02		0		44.02
45.00		0		45.00
45.02	1994 AHA LIVES	9		45.02
45.05	RADIATION OTHER OP REV	0		45.05
45.08	LABORATORY OTHER OP REV	0		45.08
45.12	LOBBY EXPENSE	0		45.12
45.13	LABOR & DELIVERY OTHER OP REV	0		45.13
45.15	SYCAMORE PRIMARY CARE OTHER OP REV	0		45.15
45.18	PHARMACY NON-PATIENT SALES	0		45.18
45.19	WOMENS HEALTH OTHER OP REV	0		45.19
45.20	SYCAMORE PRIMARY CARE	9		45.20
45.23	CAFETERIA/VENDING REVENUE	0		45.23
45.24	ASPR BIOTERRORISM	0		45.24
45.25		0		45.25

Provider CCN: 150010

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Worksheet A-8  
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Cost Center Description		Wkst. A-7 Ref.		
45.26		5.00	0	45.26
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: 150010	Period: From 07/01/2011 To 06/30/2012	Worksheet A-8-1 Date/Time Prepared: 11/28/2012 1:28 pm
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	Line No.	Cost Center	Expense Items	
	1.00	2.00	3.00	
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>				
1.00	1.00	CAP REL COSTS-BLDG & FIXT	NCI LINEN	1.00
2.00	8.00	LAUNDRY & LINEN SERVICE	NCI LINEN	2.00
3.00	1.00	CAP REL COSTS-BLDG & FIXT	TRI MEDX CAPITAL	3.00
4.00	5.06	OTHER ADMINISTRATIVE AND GENERAL	TRI MEDX OTHER	4.00
4.01	1.00	CAP REL COSTS-BLDG & FIXT	SVH CAPITAL	4.01
4.02	4.00	EMPLOYEE BENEFITS	SVH PENSION	4.02
4.03	5.06	OTHER ADMINISTRATIVE AND GENERAL	SVH A&G - SALARIES	4.03
4.10	1.00	CAP REL COSTS-BLDG & FIXT	ASCENSION HEALTH-INTEREST	4.10
4.11	5.06	OTHER ADMINISTRATIVE AND GENERAL	ASCENSION HEALTH-INTEREST	4.11
4.12	0.00		ASCENSION HEALTH-SERVICE FEE	4.12
4.14	194.04	COMMUNITY RELATIONS	SVH MARKETING-SALARIES	4.14
4.15	194.04	COMMUNITY RELATIONS	SVH MARKETING - OTHER	4.15
4.16	5.06	OTHER ADMINISTRATIVE AND GENERAL	SVH A&G - OTHER	4.16
4.17	4.00	EMPLOYEE BENEFITS	SVH - EMP BENEFITS - SALARIES	4.17
4.18	4.00	EMPLOYEE BENEFITS	SVH - EMP BENEFITS - OTHER	4.18
4.19	5.01	NONPATIENT TELEPHONES	SVH - PHONES - SALARIES	4.19
4.20	5.01	NONPATIENT TELEPHONES	SVH - PHONES - OTHER	4.20
4.21	5.02	DATA PROCESSING	SVH IT - SALARIES	4.21
4.22	5.02	DATA PROCESSING	SVH IT - OTHER	4.22
4.23	5.03	PURCHASING, RECEIVING AND STORES	SVH - PURCHASING - SALARIES	4.23
4.24	5.03	PURCHASING, RECEIVING AND STORES	SVH - PURCHASING - OTHER	4.24
4.25	5.04	ADMINISTRATIVE	SVH - ADMINISTRATIVE - SALARIES	4.25
4.26	5.04	ADMINISTRATIVE	SVH - ADMINISTRATIVE - OTHER	4.26
4.27	5.05	CASHIERING/ACCOUNTS RECEIVABLE	SVH - CASHIER - SALARIES	4.27
4.28	5.05	CASHIERING/ACCOUNTS RECEIVABLE	SVH - CASHIER - OTHER	4.28
4.33	16.00	MEDICAL RECORDS & LIBRARY	SVH - MEDICAL RECS - SALARIES	4.33
4.34	16.00	MEDICAL RECORDS & LIBRARY	SVH - MEDICAL RECS - OTHER	4.34
4.45	4.00	EMPLOYEE BENEFITS	STV SELF INSURANCE	4.45
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>B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:</b>				

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	C		0.00	6.00
7.00	B		0.00	7.00
8.00	B		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.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS  
 Provider CCN: 150010  
 Period: From 07/01/2011 To 06/30/2012  
 Worksheet A-8-1  
 Date/Time Prepared: 11/28/2012 1:28 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	
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>					
1.00	147,981	0	147,981	9	1.00
2.00	354,756	405,266	-50,510	0	2.00
3.00	23,172	20,878	2,294	9	3.00
4.00	1,669,775	1,504,479	165,296	0	4.00
4.01	1,267,922	0	1,267,922	9	4.01
4.02	0	1,821,770	-1,821,770	0	4.02
4.03	1,243,847	8,769,837	-7,525,990	0	4.03
4.10	490,599	553,673	-63,074	9	4.10
4.11	67,717	76,424	-8,707	0	4.11
4.12	0	0	0	0	4.12
4.14	324,612	0	324,612	0	4.14
4.15	1,107,252	0	1,107,252	0	4.15
4.16	1,153,495	0	1,153,495	0	4.16
4.17	202,336	0	202,336	0	4.17
4.18	769,435	0	769,435	0	4.18
4.19	92,440	0	92,440	0	4.19
4.20	23,042	0	23,042	0	4.20
4.21	1,273,954	0	1,273,954	0	4.21
4.22	2,105,921	0	2,105,921	0	4.22
4.23	44,463	0	44,463	0	4.23
4.24	84,420	0	84,420	0	4.24
4.25	20,667	0	20,667	0	4.25
4.26	-14,227	0	-14,227	0	4.26
4.27	-11,778	0	-11,778	0	4.27
4.28	23,856	0	23,856	0	4.28
4.33	108,741	0	108,741	0	4.33
4.34	27,969	0	27,969	0	4.34
4.45	5,062,019	6,117,075	-1,055,056	0	4.45
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.	17,664,386	19,269,402	-1,605,016	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>B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:</b>			

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		NCIL	0.00	LAUNDRY FACILITY	6.00
7.00		ST VINCENT HEAL	100.00	HOSPITAL MGMT	7.00
8.00		ASCENSION HEALT	100.00	HOSPITAL MGMT	8.00
9.00			0.00		9.00
10.00			0.00		10.00
100.00	G. Other (financial or non-financial) specify:				100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provi der CCN: 150010

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

Worksheet A-8-2

Date/Time Prepared:  
11/28/2012 1:28 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
	1.00	2.00	3.00	4.00	
1.00	31.00	INTENSIVE CARE UNIT	3,050	3,050	1.00
2.00	30.00	ADULTS & PEDIATRICS	412,570	412,570	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	722	722	3.00
4.00	0.00		0	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	59,583	59,583	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	58,000	58,000	6.00
7.00	65.00	RESPIRATORY THERAPY	3,050	3,050	7.00
8.00	66.00	PHYSICAL THERAPY	14,000	14,000	8.00
9.00	41.00	SUBPROVIDER - IRF	55,000	55,000	9.00
10.00	30.00	ADULTS & PEDIATRICS	127,274	127,274	10.00
11.00	76.00	PSYCH SERVICES	113,522	113,522	11.00
12.00	5.06	OTHER ADMINISTRATIVE AND GENERAL	52,043	52,043	12.00
13.00	5.06	OTHER ADMINISTRATIVE AND GENERAL	57,000	57,000	13.00
14.00	5.06	OTHER ADMINISTRATIVE AND GENERAL	132,275	132,275	14.00
15.00	5.06	OTHER ADMINISTRATIVE AND GENERAL	12,000	12,000	15.00
16.00	5.06	OTHER ADMINISTRATIVE AND GENERAL	192,500	192,500	16.00
17.00	5.06	OTHER ADMINISTRATIVE AND GENERAL	2,700	2,700	17.00
18.00	5.06	OTHER ADMINISTRATIVE AND GENERAL	201,000	201,000	18.00
19.00	5.06	OTHER ADMINISTRATIVE AND GENERAL	91,000	91,000	19.00
20.00	5.06	OTHER ADMINISTRATIVE AND GENERAL	13,300	13,300	20.00
21.00	5.06	OTHER ADMINISTRATIVE AND GENERAL	50,000	50,000	21.00
22.00	5.06	OTHER ADMINISTRATIVE AND GENERAL	15,400	15,400	22.00
23.00	5.06	OTHER ADMINISTRATIVE AND GENERAL	8,000	8,000	23.00
200.00			1,673,989	1,673,989	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 150010

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

Worksheet A-8-2

Date/Time Prepared:  
11/28/2012 1:28 pm

	Provider Component	RCE Amount	Physician/Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	5.00	6.00	7.00	8.00	9.00	
1.00	0	0	0	0	0	1.00
2.00	0	0	0	0	0	2.00
3.00	0	0	0	0	0	3.00
4.00	0	0	0	0	0	4.00
5.00	0	0	0	0	0	5.00
6.00	0	0	0	0	0	6.00
7.00	0	0	0	0	0	7.00
8.00	0	0	0	0	0	8.00
9.00	0	0	0	0	0	9.00
10.00	0	0	0	0	0	10.00
11.00	0	0	0	0	0	11.00
12.00	0	0	0	0	0	12.00
13.00	0	0	0	0	0	13.00
14.00	0	0	0	0	0	14.00
15.00	0	0	0	0	0	15.00
16.00	0	0	0	0	0	16.00
17.00	0	0	0	0	0	17.00
18.00	0	0	0	0	0	18.00
19.00	0	0	0	0	0	19.00
20.00	0	0	0	0	0	20.00
21.00	0	0	0	0	0	21.00
22.00	0	0	0	0	0	22.00
23.00	0	0	0	0	0	23.00
200.00	0	0	0	0	0	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 150010

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

Worksheet A-8-2

Date/Time Prepared:  
11/28/2012 1:28 pm

	Cost of Memberships & Continuing Education 12.00	Provider Component Share of col. 12 13.00	Physician Cost of Malpractice Insurance 14.00	Provider Component Share of col. 14 15.00	Adjusted RCE Limit 16.00	
1.00	0	0	0	0	0	1.00
2.00	0	0	0	0	0	2.00
3.00	0	0	0	0	0	3.00
4.00	0	0	0	0	0	4.00
5.00	0	0	0	0	0	5.00
6.00	0	0	0	0	0	6.00
7.00	0	0	0	0	0	7.00
8.00	0	0	0	0	0	8.00
9.00	0	0	0	0	0	9.00
10.00	0	0	0	0	0	10.00
11.00	0	0	0	0	0	11.00
12.00	0	0	0	0	0	12.00
13.00	0	0	0	0	0	13.00
14.00	0	0	0	0	0	14.00
15.00	0	0	0	0	0	15.00
16.00	0	0	0	0	0	16.00
17.00	0	0	0	0	0	17.00
18.00	0	0	0	0	0	18.00
19.00	0	0	0	0	0	19.00
20.00	0	0	0	0	0	20.00
21.00	0	0	0	0	0	21.00
22.00	0	0	0	0	0	22.00
23.00	0	0	0	0	0	23.00
200.00	0	0	0	0	0	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 150010

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

Worksheet A-8-2  
Date/Time Prepared:  
11/28/2012 1:28 pm

	RCE	Adj ustment	
	Di sal l owance	18. 00	
1. 00	17. 00	0	1. 00
2. 00		3, 050	2. 00
3. 00		412, 570	3. 00
4. 00		722	4. 00
5. 00		0	5. 00
6. 00		59, 583	6. 00
7. 00		58, 000	7. 00
8. 00		3, 050	8. 00
9. 00		14, 000	9. 00
10. 00		55, 000	10. 00
11. 00		127, 274	11. 00
12. 00		113, 522	12. 00
13. 00		52, 043	13. 00
14. 00		57, 000	14. 00
15. 00		132, 275	15. 00
16. 00		12, 000	16. 00
17. 00		192, 500	17. 00
18. 00		2, 700	18. 00
19. 00		201, 000	19. 00
20. 00		91, 000	20. 00
21. 00		13, 300	21. 00
22. 00		50, 000	22. 00
23. 00		15, 400	23. 00
200. 00		8, 000	200. 00
		1, 673, 989	

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150010

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

Worksheet B  
Part I  
Date/Time Prepared:  
11/28/2012 1:28 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	NONPATIENT TELEPHONES	
		BLDG & FIXT	MVBLE EQUIP			
		1.00	2.00			
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00101	CAP REL COSTS-BLDG & FIXT	7,970,452	7,970,452			1.00
2.00 00201	CAP REL COSTS-MVBLE EQUIP	0		0		2.00
4.00 00400	EMPLOYEE BENEFITS	11,814,395	312,962	0	12,127,357	4.00
5.01 00510	NONPATIENT TELEPHONES	161,124	7,812	0	0	168,936 5.01
5.02 00511	DATA PROCESSING	3,376,432	81,194	0	297	8,295 5.02
5.03 00512	PURCHASING, RECEIVING AND STORES	676,930	99,796	0	96,191	4,147 5.03
5.04 00513	ADMINISTRATIVE	1,140,645	40,133	0	303,714	3,318 5.04
5.05 00514	CASHIERING/ACCOUNTS RECEIVABLE	1,696,630	45,992	0	180,255	3,871 5.05
5.06 00560	OTHER ADMINISTRATIVE AND GENERAL	13,301,724	948,431	0	1,574,035	22,399 5.06
7.00 00700	OPERATION OF PLANT	3,603,010	1,122,710	0	268,095	3,318 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	422,392	12,645	0	0	276 8.00
9.00 00900	HOUSEKEEPING	1,372,199	49,190	0	229,961	1,382 9.00
10.00 01000	DIETARY	482,375	127,065	0	57,800	6,083 10.00
11.00 01100	CAFETERIA	1,130,517	154,040	0	179,707	1,382 11.00
13.00 01300	NURSING ADMINISTRATION	354,621	64,106	0	104,330	4,424 13.00
15.00 01500	PHARMACY	4,953,823	78,094	0	349,206	4,147 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	1,087,783	59,736	0	260,800	4,424 16.00
17.00 01700	SOCIAL SERVICE	417,345	69,208	0	111,238	3,041 17.00
23.00 02301	ALLIED HEALTH	126,696	21,873	0	37,528	0 23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	6,182,381	718,788	0	1,893,878	11,060 30.00
31.00 03100	INTENSIVE CARE UNIT	1,526,418	137,586	0	430,315	8,295 31.00
41.00 04100	SUBPROVIDER - IRF	1,319,697	331,222	0	375,061	5,530 41.00
43.00 04300	NURSERY	478,700	39,279	0	110,493	2,765 43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	6,853,588	820,659	0	1,029,484	5,530 50.00
51.00 05100	RECOVERY ROOM	0	0	0	0	0 51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	1,539,052	79,681	0	418,170	8,295 52.00
53.00 05300	ANESTHESIOLOGY	6,507	6,762	0	0	5,806 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	4,891,702	630,343	0	948,719	9,954 54.00
57.00 05700	CT SCAN	0	0	0	0	0 57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0 58.00
59.00 05900	CARDIAC CATHETERIZATION	347,648	9,765	0	42,928	1,935 59.00
60.00 06000	LABORATORY	5,237,406	192,855	0	546,161	1,659 60.00
65.00 06500	RESPIRATORY THERAPY	1,646,219	30,198	0	418,224	4,147 65.00
66.00 06600	PHYSICAL THERAPY	2,811,457	277,101	0	810,355	11,889 66.00
69.00 06900	ELECTROCARDIOLOGY	1,367,599	164,317	0	308,707	4,700 69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,302,661	105,191	0	101,819	553 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	3,176,225	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	288,831	0	0	0	0 73.00
74.00 07400	RENAL DIALYSIS	234,597	0	0	0	0 74.00
76.00 03020	PSYCH SERVICES	5,825	112,076	0	1,549	5,253 76.00
76.02 03022	ENDOSCOPY	497,198	0	0	103,660	0 76.02
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	742,703	73,236	0	55,698	276 90.00
91.00 09100	EMERGENCY	1,776,128	472,129	0	469,466	8,295 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					0 92.00
92.01 09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0 92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 09500	AMBULANCE SERVICES	958,065	96,867	0	240,257	553 95.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	99,279,700	7,593,042	0	12,058,101	167,002 118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	25,120	0	0	276 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	-1,074	352,290	0	0	829 192.00
194.00 07950	FOUNDATION	0	0	0	0	0 194.00
194.01 07951	CLINIC OF HOPE	280,397	0	0	69,256	829 194.01
194.04 07952	COMMUNITY RELATIONS	1,432,103	0	0	0	0 194.04
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					0 201.00
202.00	TOTAL (sum lines 118-201)	100,991,126	7,970,452	0	12,127,357	168,936 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150010

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

Worksheet B  
Part I  
Date/Time Prepared:  
11/28/2012 1:28 pm

Cost Center Description			DATA PROCESSING	PURCHASING, RECEIVING AND STORES	ADMINISTRATIVE	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	
			5.02	5.03	5.04	5.05	5A.05	
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00101	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00201	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.01	00510	NONPATIENT TELEPHONES						5.01
5.02	00511	DATA PROCESSING	3,466,218					5.02
5.03	00512	PURCHASING, RECEIVING AND STORES	46,968	924,032				5.03
5.04	00513	ADMINISTRATIVE	93,935	4,262	1,586,007			5.04
5.05	00514	CASHIERING/ACCOUNTS RECEIVABLE	28,181	1,488	0	1,956,417		5.05
5.06	00560	OTHER ADMINISTRATIVE AND GENERAL	281,806	27,818	0	0	16,156,213	5.06
7.00	00700	OPERATION OF PLANT	56,361	762	0	0	5,054,256	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	435,313	8.00
9.00	00900	HOUSEKEEPING	28,181	8,337	0	0	1,689,250	9.00
10.00	01000	DIETARY	46,968	0	0	0	720,291	10.00
11.00	01100	CAFETERIA	0	0	0	0	1,465,646	11.00
13.00	01300	NURSING ADMINISTRATION	37,574	670	0	0	565,725	13.00
15.00	01500	PHARMACY	93,935	9,328	0	0	5,488,533	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	112,723	1,610	0	0	1,527,076	16.00
17.00	01700	SOCIAL SERVICE	46,968	559	0	0	648,359	17.00
23.00	02301	ALLIED HEALTH	0	0	0	0	186,097	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	197,264	76,404	115,330	142,251	9,337,356	30.00
31.00	03100	INTENSIVE CARE UNIT	328,774	38,901	25,288	31,191	2,526,768	31.00
41.00	04100	SUBPROVIDER - IRF	103,329	12,949	22,200	27,382	2,197,370	41.00
43.00	04300	NURSERY	9,394	0	15,318	18,893	674,842	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	591,792	427,019	200,526	247,335	10,175,933	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	46,968	46,320	44,834	55,300	2,238,620	52.00
53.00	05300	ANESTHESIOLOGY	9,394	607	30,066	37,084	96,226	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	159,690	29,145	324,731	400,719	7,395,003	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	37,574	31,926	29,615	36,528	537,919	59.00
60.00	06000	LABORATORY	281,806	18,008	240,563	296,718	6,815,176	60.00
65.00	06500	RESPIRATORY THERAPY	37,574	5,620	44,115	54,413	2,240,510	65.00
66.00	06600	PHYSICAL THERAPY	225,445	4,232	84,419	104,126	4,329,024	66.00
69.00	06900	ELECTROCARDIOLOGY	0	9,908	60,176	74,223	1,989,630	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	80,595	72,914	89,935	3,753,668	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	22,833	28,163	3,227,221	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	48,517	59,842	397,190	73.00
74.00	07400	RENAL DIALYSIS	9,394	2,589	1,075	1,326	248,981	74.00
76.00	03020	PSYCH SERVICES	112,723	0	2,739	3,378	243,543	76.00
76.02	03022	ENDOSCOPY	0	31,714	44,570	54,974	732,116	76.02
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	37,574	8,944	25,947	32,004	976,382	90.00
91.00	09100	EMERGENCY	328,774	38,090	107,408	132,481	3,332,771	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES	9,394	5,665	22,823	28,151	1,361,775	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,400,463	923,470	1,586,007	1,956,417	98,764,783	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	25,396	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	28,181	0	0	0	380,226	192.00
194.00	07950	FOUNDATION	0	0	0	0	0	194.00
194.01	07951	CLINIC OF HOPE	37,574	562	0	0	388,618	194.01
194.04	07952	COMMUNITY RELATIONS	0	0	0	0	1,432,103	194.04
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)	3,466,218	924,032	1,586,007	1,956,417	100,991,126	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150010

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

Worksheet B  
Part I  
Date/Time Prepared:  
11/28/2012 1:28 pm

Cost Center Description			OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.06	7.00	8.00	9.00	10.00	
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00101	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00201	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.01	00510	NONPATIENT TELEPHONES						5.01
5.02	00511	DATA PROCESSING						5.02
5.03	00512	PURCHASING, RECEIVING AND STORES						5.03
5.04	00513	ADMINISTRATIVE						5.04
5.05	00514	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00560	OTHER ADMINISTRATIVE AND GENERAL	16,156,213					5.06
7.00	00700	OPERATION OF PLANT	962,548	6,016,804				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	82,902	14,325	532,540			8.00
9.00	00900	HOUSEKEEPING	321,706	55,723	0	2,066,679		9.00
10.00	01000	DIETARY	137,174	143,939	10,035	0	1,011,439	10.00
11.00	01100	CAFETERIA	279,122	174,497	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	107,738	72,620	0	2,051	0	13.00
15.00	01500	PHARMACY	1,045,253	88,465	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	290,821	67,669	0	3,077	0	16.00
17.00	01700	SOCIAL SERVICE	123,475	78,399	0	1,026	0	17.00
23.00	02301	ALLIED HEALTH	35,441	24,778	0	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	1,778,234	814,246	185,793	647,184	790,296	30.00
31.00	03100	INTENSIVE CARE UNIT	481,205	155,858	24,151	153,847	32,693	31.00
41.00	04100	SUBPROVIDER - IRF	418,474	375,210	39,404	153,847	188,450	41.00
43.00	04300	NURSERY	128,519	44,495	0	30,769	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	1,937,932	929,650	96,085	307,694	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	426,330	90,263	51,220	261,540	0	52.00
53.00	05300	ANESTHESIOLOGY	18,326	7,660	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,408,327	714,055	34,018	62,564	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	102,443	11,062	3,088	12,308	0	59.00
60.00	06000	LABORATORY	1,297,903	218,467	468	63,590	0	60.00
65.00	06500	RESPIRATORY THERAPY	426,689	34,208	25	3,077	0	65.00
66.00	06600	PHYSICAL THERAPY	824,432	313,901	3,564	15,385	0	66.00
69.00	06900	ELECTROCARDIOLOGY	378,911	186,139	5,118	33,846	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	714,860	119,161	0	57,436	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	614,602	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	75,642	0	0	24,616	0	73.00
74.00	07400	RENAL DIALYSIS	47,417	0	0	10,256	0	74.00
76.00	03020	PSYCH SERVICES	46,381	126,960	0	0	0	76.00
76.02	03022	ENDOSCOPY	139,426	0	0	0	0	76.02
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	185,945	82,962	25	32,821	0	90.00
91.00	09100	EMERGENCY	634,703	534,829	75,043	189,745	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES	259,341	109,731	0	0	0	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	15,732,222	5,589,272	528,037	2,066,679	1,011,439	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,836	28,456	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	72,411	399,076	4,503	0	0	192.00
194.00	07950	FOUNDATION	0	0	0	0	0	194.00
194.01	07951	CLINIC OF HOPE	74,010	0	0	0	0	194.01
194.04	07952	COMMUNITY RELATIONS	272,734	0	0	0	0	194.04
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)	16,156,213	6,016,804	532,540	2,066,679	1,011,439	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 150010		Period: From 07/01/2011 To 06/30/2012		Worksheet B Part I Date/Time Prepared: 11/28/2012 1:28 pm	
Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		11.00	13.00	15.00	16.00	17.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00101						1.00
2.00	00201						2.00
4.00	00400						4.00
5.01	00510						5.01
5.02	00511						5.02
5.03	00512						5.03
5.04	00513						5.04
5.05	00514						5.05
5.06	00560						5.06
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	1,919,265					11.00
13.00	01300	16,182	764,316				13.00
15.00	01500	50,215	0	6,672,466			15.00
16.00	01600	77,468	0	0	1,966,111		16.00
17.00	01700	22,961	0	0	0	874,220	17.00
23.00	02301	6,924	0	0	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	417,859	182,969	0	142,970	610,838	30.00
31.00	03100	82,975	36,332	0	31,348	74,309	31.00
41.00	04100	88,794	38,881	0	27,521	142,778	41.00
43.00	04300	21,387	9,365	0	18,989	46,295	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	214,098	93,748	0	248,586	0	50.00
51.00	05100	0	0	0	0	0	51.00
52.00	05200	80,943	35,443	0	55,579	0	52.00
53.00	05300	0	0	0	37,272	0	53.00
54.00	05400	189,362	82,917	0	402,546	0	54.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	7,168	3,139	0	36,713	0	59.00
60.00	06000	124,415	54,478	0	298,218	0	60.00
65.00	06500	77,325	33,859	0	54,688	0	65.00
66.00	06600	137,106	60,035	0	104,652	0	66.00
69.00	06900	62,296	27,278	0	74,598	0	69.00
71.00	07100	32,110	14,060	0	90,389	0	71.00
72.00	07200	0	0	0	28,306	0	72.00
73.00	07300	0	0	6,672,466	60,145	0	73.00
74.00	07400	0	0	0	1,333	0	74.00
76.00	03020	176	77	0	3,396	0	76.00
76.02	03022	17,720	7,759	0	55,252	0	76.02
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	15,217	6,663	0	32,166	0	90.00
91.00	09100	88,493	38,749	0	133,151	0	91.00
92.00	09200						92.00
92.01	09201	0	0	0	0	0	92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	73,478	32,174	0	28,293	0	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
118.00		1,904,672	757,926	6,672,466	1,966,111	874,220	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	14,593	6,390	0	0	0	194.01
194.04	07952	0	0	0	0	0	194.04
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		1,919,265	764,316	6,672,466	1,966,111	874,220	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150010

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

Worksheet B  
Part I  
Date/Time Prepared:  
11/28/2012 1:28 pm

Cost Center Description		ALLIED HEALTH	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		23.00	24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	00101	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00201	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS				4.00
5.01	00510	NONPATIENT TELEPHONES				5.01
5.02	00511	DATA PROCESSING				5.02
5.03	00512	PURCHASING, RECEIVING AND STORES				5.03
5.04	00513	ADMITTING				5.04
5.05	00514	CASHIERING/ACCOUNTS RECEIVABLE				5.05
5.06	00560	OTHER ADMINISTRATIVE AND GENERAL				5.06
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
23.00	02301	ALLIED HEALTH	253,240			23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000	ADULTS & PEDIATRICS	0	14,907,745	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	3,599,486	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	3,670,729	0	41.00
43.00	04300	NURSERY	0	974,661	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	OPERATING ROOM	0	14,003,726	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,239,938	0	52.00
53.00	05300	ANESTHESIOLOGY	0	159,484	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	253,240	10,542,032	0	54.00
57.00	05700	CT SCAN	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	713,840	0	59.00
60.00	06000	LABORATORY	0	8,872,715	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,870,381	0	65.00
66.00	06600	PHYSICAL THERAPY	0	5,788,099	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	2,757,816	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,781,684	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,870,129	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,230,059	0	73.00
74.00	07400	RENAL DIALYSIS	0	307,987	0	74.00
76.00	03020	PSYCH SERVICES	0	420,533	0	76.00
76.02	03022	ENDOSCOPY	0	952,273	0	76.02
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000	CLINIC	0	1,332,181	0	90.00
91.00	09100	EMERGENCY	0	5,027,484	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00	09500	AMBULANCE SERVICES	0	1,864,792	0	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	253,240	97,887,774	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	58,688	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	856,216	0	192.00
194.00	07950	FOUNDATION	0	0	0	194.00
194.01	07951	CLINIC OF HOPE	0	483,611	0	194.01
194.04	07952	COMMUNITY RELATIONS	0	1,704,837	0	194.04
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	253,240	100,991,126	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150010

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

Worksheet B Part II Date/Time Prepared: 11/28/2012 1:28 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00101	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00201	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS	0	312,962	0	312,962	4.00
5.01 00510	NONPATIENT TELEPHONES	0	7,812	0	7,812	5.01
5.02 00511	DATA PROCESSING	0	81,194	0	81,194	5.02
5.03 00512	PURCHASING, RECEIVING AND STORES	0	99,796	0	99,796	5.03
5.04 00513	ADMINITTING	0	40,133	0	40,133	5.04
5.05 00514	CASHIERING/ACCOUNTS RECEIVABLE	0	45,992	0	45,992	5.05
5.06 00560	OTHER ADMINISTRATIVE AND GENERAL	0	948,431	0	948,431	5.06
7.00 00700	OPERATION OF PLANT	0	1,122,710	0	1,122,710	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	12,645	0	12,645	8.00
9.00 00900	HOUSEKEEPING	0	49,190	0	49,190	9.00
10.00 01000	DIETARY	0	127,065	0	127,065	10.00
11.00 01100	CAFETERIA	0	154,040	0	154,040	11.00
13.00 01300	NURSING ADMINISTRATION	0	64,106	0	64,106	13.00
15.00 01500	PHARMACY	0	78,094	0	78,094	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	59,736	0	59,736	16.00
17.00 01700	SOCIAL SERVICE	0	69,208	0	69,208	17.00
23.00 02301	ALLIED HEALTH	0	21,873	0	21,873	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	0	718,788	0	718,788	30.00
31.00 03100	INTENSIVE CARE UNIT	0	137,586	0	137,586	31.00
41.00 04100	SUBPROVIDER - IRF	0	331,222	0	331,222	41.00
43.00 04300	NURSERY	0	39,279	0	39,279	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	0	820,659	0	820,659	50.00
51.00 05100	RECOVERY ROOM	0	0	0	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	79,681	0	79,681	52.00
53.00 05300	ANESTHESIOLOGY	0	6,762	0	6,762	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	630,343	0	630,343	54.00
57.00 05700	CT SCAN	0	0	0	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	9,765	0	9,765	59.00
60.00 06000	LABORATORY	0	192,855	0	192,855	60.00
65.00 06500	RESPIRATORY THERAPY	0	30,198	0	30,198	65.00
66.00 06600	PHYSICAL THERAPY	0	277,101	0	277,101	66.00
69.00 06900	ELECTROCARDIOLOGY	0	164,317	0	164,317	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	105,191	0	105,191	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
76.00 03020	PSYCH SERVICES	0	112,076	0	112,076	76.00
76.02 03022	ENDOSCOPY	0	0	0	0	76.02
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	0	73,236	0	73,236	90.00
91.00 09100	EMERGENCY	0	472,129	0	472,129	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
92.01 09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 09500	AMBULANCE SERVICES	0	96,867	0	96,867	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	7,593,042	0	7,593,042	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	25,120	0	25,120	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	352,290	0	352,290	192.00
194.00 07950	FOUNDATION	0	0	0	0	194.00
194.01 07951	CLINIC OF HOPE	0	0	0	0	194.01
194.04 07952	COMMUNITY RELATIONS	0	0	0	0	194.04
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	7,970,452	0	7,970,452	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150010		Period: From 07/01/2011 To 06/30/2012		Worksheet B Part II Date/Time Prepared: 11/28/2012 1:28 pm		
Cost Center Description		NONPATIENT TELEPHONES	DATA PROCESSING	PURCHASING, RECEIVING AND STORES	ADMINITTING	CASHIERING/AC COUNTS RECEIVABLE		
		5.01	5.02	5.03	5.04	5.05		
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00101	CAP REL COSTS-BLDG & FIXT					1.00	
2.00	00201	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS					4.00	
5.01	00510	NONPATIENT TELEPHONES	7,812				5.01	
5.02	00511	DATA PROCESSING	384	81,586			5.02	
5.03	00512	PURCHASING, RECEIVING AND STORES	192	1,106	103,576		5.03	
5.04	00513	ADMINITTING	153	2,211	478	50,813	5.04	
5.05	00514	CASHIERING/ACCOUNTS RECEIVABLE	179	663	167	0	5.05	
5.06	00560	OTHER ADMINISTRATION AND GENERAL	1,033	6,633	3,118	0	5.06	
7.00	00700	OPERATION OF PLANT	153	1,327	85	0	7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	13	0	0	0	8.00	
9.00	00900	HOUSEKEEPING	64	663	935	0	9.00	
10.00	01000	DIETARY	281	1,106	0	0	10.00	
11.00	01100	CAFETERIA	64	0	0	0	11.00	
13.00	01300	NURSING ADMINISTRATION	205	884	75	0	13.00	
15.00	01500	PHARMACY	192	2,211	1,046	0	15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	205	2,653	180	0	16.00	
17.00	01700	SOCIAL SERVICE	141	1,106	63	0	17.00	
23.00	02301	ALLIED HEALTH	0	0	0	0	23.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	511	4,643	8,564	3,701	3,755	30.00
31.00	03100	INTENSIVE CARE UNIT	384	7,739	4,360	812	823	31.00
41.00	04100	SUBPROVIDER - IRF	256	2,432	1,451	712	723	41.00
43.00	04300	NURSERY	128	221	0	492	499	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	256	13,930	47,865	6,436	6,528	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	384	1,106	5,192	1,439	1,460	52.00
53.00	05300	ANESTHESIOLOGY	268	221	68	965	979	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	460	3,759	3,267	10,334	10,590	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	89	884	3,579	950	964	59.00
60.00	06000	LABORATORY	77	6,633	2,019	7,721	7,832	60.00
65.00	06500	RESPIRATORY THERAPY	192	884	630	1,416	1,436	65.00
66.00	06600	PHYSICAL THERAPY	550	5,306	474	2,709	2,748	66.00
69.00	06900	ELECTROCARDIOLOGY	217	0	1,111	1,931	1,959	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	26	0	9,034	2,340	2,374	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	733	743	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,557	1,580	73.00
74.00	07400	RENAL DIALYSIS	0	221	290	35	35	74.00
76.00	03020	PSYCH SERVICES	243	2,653	0	88	89	76.00
76.02	03022	ENDOSCOPY	0	0	3,555	1,430	1,451	76.02
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	13	884	1,003	833	845	90.00
91.00	09100	EMERGENCY	384	7,739	4,269	3,447	3,497	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES	26	221	635	732	743	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	7,723	80,039	103,513	50,813	51,653	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	13	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	38	663	0	0	0	192.00
194.00	07950	FOUNDATION	0	0	0	0	0	194.00
194.01	07951	CLINIC OF HOPE	38	884	63	0	0	194.01
194.04	07952	COMMUNITY RELATIONS	0	0	0	0	0	194.04
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)	7,812	81,586	103,576	50,813	51,653	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150010	Period: From 07/01/2011 To 06/30/2012	Worksheet B Part II Date/Time Prepared: 11/28/2012 1:28 pm
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Cost Center Description		OTHER ADMINISTRATIVE AND GENERAL 5.06	OPERATION OF PLANT 7.00	LAUNDRY & LINEN SERVICE 8.00	HOUSEKEEPING 9.00	DIETARY 10.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00101	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00201	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.01	00510	NONPATIENT TELEPHONES					5.01
5.02	00511	DATA PROCESSING					5.02
5.03	00512	PURCHASING, RECEIVING AND STORES					5.03
5.04	00513	ADMINISTRATIVE					5.04
5.05	00514	CASHIERING/ACCOUNTS RECEIVABLE					5.05
5.06	00560	OTHER ADMINISTRATIVE AND GENERAL	999,835				5.06
7.00	00700	OPERATION OF PLANT	59,569	1,190,763			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	5,131	2,835	20,624		8.00
9.00	00900	HOUSEKEEPING	19,910	11,028	0	87,724	9.00
10.00	01000	DIETARY	8,489	28,486	389	0	167,308
11.00	01100	CAFETERIA	17,274	34,534	0	0	0
13.00	01300	NURSING ADMINISTRATION	6,668	14,372	0	87	0
15.00	01500	PHARMACY	64,688	17,508	0	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	17,998	13,392	0	131	0
17.00	01700	SOCIAL SERVICE	7,642	15,516	0	44	0
23.00	02301	ALLIED HEALTH	2,193	4,904	0	0	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	110,050	161,144	7,196	27,470	130,727
31.00	03100	INTENSIVE CARE UNIT	29,780	30,845	935	6,530	5,408
41.00	04100	SUBPROVIDER - IRF	25,898	74,256	1,526	6,530	31,173
43.00	04300	NURSERY	7,954	8,806	0	1,306	0
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	119,904	183,982	3,721	13,061	0
51.00	05100	RECOVERY ROOM	0	0	0	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	26,384	17,864	1,984	11,102	0
53.00	05300	ANESTHESIOLOGY	1,134	1,516	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	87,158	141,316	1,317	2,656	0
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	6,340	2,189	120	522	0
60.00	06000	LABORATORY	80,324	43,236	18	2,699	0
65.00	06500	RESPIRATORY THERAPY	26,407	6,770	1	131	0
66.00	06600	PHYSICAL THERAPY	51,022	62,123	138	653	0
69.00	06900	ELECTROCARDIOLOGY	23,450	36,838	198	1,437	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	44,241	23,583	0	2,438	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	38,036	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	4,681	0	0	1,045	0
74.00	07400	RENAL DIALYSIS	2,934	0	0	435	0
76.00	03020	PSYCH SERVICES	2,870	25,126	0	0	0
76.02	03022	ENDOSCOPY	8,629	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	11,508	16,419	1	1,393	0
91.00	09100	EMERGENCY	39,280	105,846	2,906	8,054	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	16,050	21,717	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	973,596	1,106,151	20,450	87,724	167,308
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	299	5,632	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,481	78,980	174	0	0
194.00	07950	FOUNDATION	0	0	0	0	0
194.01	07951	CLINIC OF HOPE	4,580	0	0	0	0
194.04	07952	COMMUNITY RELATIONS	16,879	0	0	0	0
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	999,835	1,190,763	20,624	87,724	167,308

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150010		Period: From 07/01/2011 To 06/30/2012		Worksheet B Part II Date/Time Prepared: 11/28/2012 1:28 pm	
Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		11.00	13.00	15.00	16.00	17.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00101						1.00
2.00	00201						2.00
4.00	00400						4.00
5.01	00510						5.01
5.02	00511						5.02
5.03	00512						5.03
5.04	00513						5.04
5.05	00514						5.05
5.06	00560						5.06
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	210,550					11.00
13.00	01300	1,775	90,864				13.00
15.00	01500	5,509	0	178,260			15.00
16.00	01600	8,499	0	0	109,524		16.00
17.00	01700	2,519	0	0	0	99,110	17.00
23.00	02301	760	0	0	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	45,839	21,753	0	7,962	69,251	30.00
31.00	03100	9,103	4,319	0	1,746	8,424	31.00
41.00	04100	9,741	4,622	0	1,533	16,187	41.00
43.00	04300	2,346	1,113	0	1,057	5,248	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	23,487	11,145	0	13,844	0	50.00
51.00	05100	0	0	0	0	0	51.00
52.00	05200	8,880	4,214	0	3,095	0	52.00
53.00	05300	0	0	0	2,076	0	53.00
54.00	05400	20,774	9,857	0	22,449	0	54.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	786	373	0	2,045	0	59.00
60.00	06000	13,649	6,476	0	16,608	0	60.00
65.00	06500	8,483	4,025	0	3,046	0	65.00
66.00	06600	15,041	7,137	0	5,828	0	66.00
69.00	06900	6,834	3,243	0	4,154	0	69.00
71.00	07100	3,523	1,672	0	5,034	0	71.00
72.00	07200	0	0	0	1,576	0	72.00
73.00	07300	0	0	178,260	3,349	0	73.00
74.00	07400	0	0	0	74	0	74.00
76.00	03020	19	9	0	189	0	76.00
76.02	03022	1,944	922	0	3,077	0	76.02
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	1,669	792	0	1,791	0	90.00
91.00	09100	9,708	4,607	0	7,415	0	91.00
92.00	09200						92.00
92.01	09201	0	0	0	0	0	92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	8,061	3,825	0	1,576	0	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
118.00		208,949	90,104	178,260	109,524	99,110	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	1,601	760	0	0	0	194.01
194.04	07952	0	0	0	0	0	194.04
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		210,550	90,864	178,260	109,524	99,110	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provi der CCN: 150010	Period: From 07/01/2011 To 06/30/2012	Worksheet B Part II Date/Time Prepared: 11/28/2012 1:28 pm		
Cost Center	Description	ALLIED HEALTH	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		23.00	24.00	25.00	26.00		
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00101	CAP REL COSTS-BLDG & FIXT				1.00	
2.00	00201	CAP REL COSTS-MVBLE EQUIP				2.00	
4.00	00400	EMPLOYEE BENEFITS				4.00	
5.01	00510	NONPATIENT TELEPHONES				5.01	
5.02	00511	DATA PROCESSING				5.02	
5.03	00512	PURCHASING, RECEIVING AND STORES				5.03	
5.04	00513	ADMITTING				5.04	
5.05	00514	CASHIERING/ACCOUNTS RECEIVABLE				5.05	
5.06	00560	OTHER ADMINISTRATIVE AND GENERAL				5.06	
7.00	00700	OPERATION OF PLANT				7.00	
8.00	00800	LAUNDRY & LINEN SERVICE				8.00	
9.00	00900	HOUSEKEEPING				9.00	
10.00	01000	DIETARY				10.00	
11.00	01100	CAFETERIA				11.00	
13.00	01300	NURSING ADMINISTRATION				13.00	
15.00	01500	PHARMACY				15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00	
17.00	01700	SOCIAL SERVICE				17.00	
23.00	02301	ALLIED HEALTH	30,698			23.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	1,370,228	0	1,370,228	30.00	
31.00	03100	INTENSIVE CARE UNIT	259,899	0	259,899	31.00	
41.00	04100	SUBPROVIDER - IRF	517,941	0	517,941	41.00	
43.00	04300	NURSERY	71,300	0	71,300	43.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	1,291,385	0	1,291,385	50.00	
51.00	05100	RECOVERY ROOM	0	0	0	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	173,576	0	173,576	52.00	
53.00	05300	ANESTHESIOLOGY	13,989	0	13,989	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	968,763	0	968,763	54.00	
57.00	05700	CT SCAN	0	0	0	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00	
59.00	05900	CARDIAC CATHETERIZATION	29,714	0	29,714	59.00	
60.00	06000	LABORATORY	394,241	0	394,241	60.00	
65.00	06500	RESPIRATORY THERAPY	94,412	0	94,412	65.00	
66.00	06600	PHYSICAL THERAPY	451,742	0	451,742	66.00	
69.00	06900	ELECTROCARDIOLOGY	253,656	0	253,656	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	202,084	0	202,084	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	41,088	0	41,088	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	190,472	0	190,472	73.00	
74.00	07400	RENAL DIALYSIS	4,024	0	4,024	74.00	
76.00	03020	PSYCH SERVICES	143,402	0	143,402	76.00	
76.02	03022	ENDOSCOPY	23,683	0	23,683	76.02	
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	111,824	0	111,824	90.00	
91.00	09100	EMERGENCY	681,396	0	681,396	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0		92.00	
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	92.01	
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	156,653	0	156,653	95.00	
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE				113.00	
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	7,445,472	0	7,445,472	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	31,064	0	31,064	190.00	
192.00	19200	PHYSICIANS' PRIVATE OFFICES	436,626	0	436,626	192.00	
194.00	07950	FOUNDATION	0	0	0	194.00	
194.01	07951	CLINIC OF HOPE	9,713	0	9,713	194.01	
194.04	07952	COMMUNITY RELATIONS	16,879	0	16,879	194.04	
200.00		Cross Foot Adjustments	30,698	0	30,698	200.00	
201.00		Negative Cost Centers	0	0	0	201.00	
202.00		TOTAL (sum lines 118-201)	30,698	7,970,452	0	7,970,452	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150010

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

Worksheet B-1

Date/Time Prepared:  
11/28/2012 1:28 pm

Cost Center Description	CAPITAL RELATED COSTS					
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (NO STATISTIC)	EMPLOYEE BENEFITS (GROSS SALARIES)	NONPATIENT TELEPHONES (# OF PHONES)	DATA PROCESSING (# OF TERMINALS)	
	1.00	2.00	4.00	5.01	5.02	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00101	CAP REL COSTS-BLDG & FIXT	326,497				1.00
2.00 00201	CAP REL COSTS-MVBLE EQUIP		0			2.00
4.00 00400	EMPLOYEE BENEFITS	12,820	0	40,942,424		4.00
5.01 00510	NONPATIENT TELEPHONES	320	0	0	611	5.01
5.02 00511	DATA PROCESSING	3,326	0	1,002	30	369 5.02
5.03 00512	PURCHASING, RECEIVING AND STORES	4,088	0	324,743	15	5 5.03
5.04 00513	ADMINISTRATIVE	1,644	0	1,025,349	12	10 5.04
5.05 00514	CASHIERING/ACCOUNTS RECEIVABLE	1,884	0	608,548	14	3 5.05
5.06 00560	OTHER ADMINISTRATIVE AND GENERAL	38,851	0	5,314,004	81	30 5.06
7.00 00700	OPERATION OF PLANT	45,990	0	905,098	12	6 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	518	0	0	1	0 8.00
9.00 00900	HOUSEKEEPING	2,015	0	776,359	5	3 9.00
10.00 01000	DIETARY	5,205	0	195,135	22	5 10.00
11.00 01100	CAFETERIA	6,310	0	606,698	5	0 11.00
13.00 01300	NURSING ADMINISTRATION	2,626	0	352,222	16	4 13.00
15.00 01500	PHARMACY	3,199	0	1,178,934	15	10 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	2,447	0	880,470	16	12 16.00
17.00 01700	SOCIAL SERVICE	2,835	0	375,545	11	5 17.00
23.00 02301	ALLIED HEALTH	896	0	126,696	0	0 23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	29,444	0	6,393,789	40	21 30.00
31.00 03100	INTENSIVE CARE UNIT	5,636	0	1,452,760	30	35 31.00
41.00 04100	SUBPROVIDER - IRF	13,568	0	1,266,221	20	11 41.00
43.00 04300	NURSERY	1,609	0	373,028	10	1 43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	33,617	0	3,475,580	20	63 50.00
51.00 05100	RECOVERY ROOM	0	0	0	0	0 51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	3,264	0	1,411,758	30	5 52.00
53.00 05300	ANESTHESIOLOGY	277	0	0	21	1 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	25,821	0	3,202,915	36	17 54.00
57.00 05700	CT SCAN	0	0	0	0	0 57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0 58.00
59.00 05900	CARDIAC CATHETERIZATION	400	0	144,927	7	4 59.00
60.00 06000	LABORATORY	7,900	0	1,843,863	6	30 60.00
65.00 06500	RESPIRATORY THERAPY	1,237	0	1,411,942	15	4 65.00
66.00 06600	PHYSICAL THERAPY	11,351	0	2,735,790	43	24 66.00
69.00 06900	ELECTROCARDIOLOGY	6,731	0	1,042,207	17	0 69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,309	0	343,744	2	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	1 74.00
76.00 03020	PSYCH SERVICES	4,591	0	5,230	19	12 76.00
76.02 03022	ENDOSCOPY	0	0	349,961	0	0 76.02
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	3,000	0	188,039	1	4 90.00
91.00 09100	EMERGENCY	19,340	0	1,584,937	30	35 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
92.01 09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0 92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 09500	AMBULANCE SERVICES	3,968	0	811,118	2	1 95.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	311,037	0	40,708,612	604	362 118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,029	0	0	1	0 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	14,431	0	0	3	3 192.00
194.00 07950	FOUNDATION	0	0	0	0	0 194.00
194.01 07951	CLINIC OF HOPE	0	0	233,812	3	4 194.01
194.04 07952	COMMUNITY RELATIONS	0	0	0	0	0 194.04
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	7,970,452	0	12,127,357	168,936	3,466,218 202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	24.412022	0.000000	0.296205	276.490998	9,393.544715 203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			312,962	7,812	81,586 204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.007644	12.785597	221.100271 205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150010

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

Worksheet B-1

Date/Time Prepared:  
11/28/2012 1:28 pm

Cost Center Description		PURCHASING, RECEIVING AND STORES (COSTED REQUISITION)	ADMINISTRATIVE (GROSS REVENUE)	CASHIERING/AC COUNTS RECEIVABLE (GROSS REVENUE)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	
		5.03	5.04	5.05	5A.06	5.06	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00101						1.00
2.00	00201						2.00
4.00	00400						4.00
5.01	00510						5.01
5.02	00511						5.02
5.03	00512	5,236,308					5.03
5.04	00513	24,151	366,222,951				5.04
5.05	00514	8,434	0	366,222,951			5.05
5.06	00560	157,639	0	0	-16,156,213	84,834,913	5.06
7.00	00700	4,316	0	0	0	5,054,256	7.00
8.00	00800	0	0	0	0	435,313	8.00
9.00	00900	47,246	0	0	0	1,689,250	9.00
10.00	01000	0	0	0	0	720,291	10.00
11.00	01100	0	0	0	0	1,465,646	11.00
13.00	01300	3,799	0	0	0	565,725	13.00
15.00	01500	52,859	0	0	0	5,488,533	15.00
16.00	01600	9,122	0	0	0	1,527,076	16.00
17.00	01700	3,166	0	0	0	648,359	17.00
23.00	02301	0	0	0	0	186,097	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	432,965	26,628,852	26,628,852	0	9,337,356	30.00
31.00	03100	220,446	5,838,789	5,838,789	0	2,526,768	31.00
41.00	04100	73,382	5,125,829	5,125,829	0	2,197,370	41.00
43.00	04300	0	3,536,736	3,536,736	0	674,842	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	2,419,834	46,300,160	46,300,160	0	10,175,933	50.00
51.00	05100	0	0	0	0	0	51.00
52.00	05200	262,489	10,351,863	10,351,863	0	2,238,620	52.00
53.00	05300	3,439	6,942,010	6,942,010	0	96,226	53.00
54.00	05400	165,160	75,002,421	75,002,421	0	7,395,003	54.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	180,917	6,837,942	6,837,942	0	537,919	59.00
60.00	06000	102,048	55,544,431	55,544,431	0	6,815,176	60.00
65.00	06500	31,845	10,185,813	10,185,813	0	2,240,510	65.00
66.00	06600	23,980	19,491,899	19,491,899	0	4,329,024	66.00
69.00	06900	56,144	13,894,239	13,894,239	0	1,989,630	69.00
71.00	07100	456,719	16,835,435	16,835,435	0	3,753,668	71.00
72.00	07200	0	5,272,030	5,272,030	0	3,227,221	72.00
73.00	07300	0	11,202,191	11,202,191	0	397,190	73.00
74.00	07400	14,672	248,240	248,240	0	248,981	74.00
76.00	03020	0	632,433	632,433	0	243,543	76.00
76.02	03022	179,715	10,290,922	10,290,922	0	732,116	76.02
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	50,686	5,991,075	5,991,075	0	976,382	90.00
91.00	09100	215,848	24,799,904	24,799,904	0	3,332,771	91.00
92.00	09200						92.00
92.01	09201	0	0	0	0	0	92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	32,100	5,269,737	5,269,737	0	1,361,775	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
118.00		5,233,121	366,222,951	366,222,951	-16,156,213	82,608,570	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	25,396	190.00
192.00	19200	0	0	0	0	380,226	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	3,187	0	0	0	388,618	194.01
194.04	07952	0	0	0	0	1,432,103	194.04
200.00							200.00
201.00							201.00
202.00		924,032	1,586,007	1,956,417		16,156,213	202.00
203.00		0.176466	0.004331	0.005342		0.190443	203.00
204.00		103,576	50,813	51,653		999,835	204.00
205.00		0.019780	0.000139	0.000141		0.011786	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150010

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

Worksheet B-1

Date/Time Prepared:  
11/28/2012 1:28 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MANHOURS)		
		7.00	8.00	9.00	10.00	11.00		
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00101	CAP REL COSTS-BLDG & FIXT					1.00	
2.00	00201	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS					4.00	
5.01	00510	NONPATIENT TELEPHONES					5.01	
5.02	00511	DATA PROCESSING					5.02	
5.03	00512	PURCHASING, RECEIVING AND STORES					5.03	
5.04	00513	ADMITTING					5.04	
5.05	00514	CASHIERING/ACCOUNTS RECEIVABLE					5.05	
5.06	00560	OTHER ADMINISTRATIVE AND GENERAL					5.06	
7.00	00700	OPERATION OF PLANT	217,574				7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	518	822,154			8.00	
9.00	00900	HOUSEKEEPING	2,015	0	2,015		9.00	
10.00	01000	DIETARY	5,205	15,493	0	69,671	10.00	
11.00	01100	CAFETERIA	6,310	0	0	0	11.00	
13.00	01300	NURSING ADMINISTRATION	2,626	0	2	0	13.00	
15.00	01500	PHARMACY	3,199	0	0	0	15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	2,447	0	3	0	16.00	
17.00	01700	SOCIAL SERVICE	2,835	0	1	0	17.00	
23.00	02301	ALLIED HEALTH	896	0	0	0	23.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	29,444	286,831	631	54,438	271,142	30.00
31.00	03100	INTENSIVE CARE UNIT	5,636	37,285	150	2,252	53,841	31.00
41.00	04100	SUBPROVIDER - IRF	13,568	60,834	150	12,981	57,617	41.00
43.00	04300	NURSERY	1,609	0	30	0	13,878	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	33,617	148,340	300	0	138,925	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,264	79,075	255	0	52,523	52.00
53.00	05300	ANESTHESIOLOGY	277	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	25,821	52,518	61	0	122,874	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	400	4,768	12	0	4,651	59.00
60.00	06000	LABORATORY	7,900	723	62	0	80,731	60.00
65.00	06500	RESPIRATORY THERAPY	1,237	39	3	0	50,175	65.00
66.00	06600	PHYSICAL THERAPY	11,351	5,502	15	0	88,966	66.00
69.00	06900	ELECTROCARDIOLOGY	6,731	7,902	33	0	40,423	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,309	0	56	0	20,836	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	24	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	10	0	0	74.00
76.00	03020	PSYCH SERVICES	4,591	0	0	0	114	76.00
76.02	03022	ENDOSCOPY	0	0	0	0	11,498	76.02
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	3,000	38	32	0	9,874	90.00
91.00	09100	EMERGENCY	19,340	115,854	185	0	57,422	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES	3,968	0	0	0	47,679	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	202,114	815,202	2,015	69,671	1,235,913	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,029	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	14,431	6,952	0	0	0	192.00
194.00	07950	FOUNDATION	0	0	0	0	0	194.00
194.01	07951	CLINIC OF HOPE	0	0	0	0	9,469	194.01
194.04	07952	COMMUNITY RELATIONS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	6,016,804	532,540	2,066,679	1,011,439	1,919,265	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	27.654058	0.647738	1,025.647146	14.517360	1.541105	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,190,763	20,624	87,724	167,308	210,550	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	5.472910	0.025085	43.535484	2.401401	0.169065	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150010

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

Worksheet B-1

Date/Time Prepared:  
11/28/2012 1:28 pm

Cost Center Description		NURSING ADMINISTRATION (DIRECT NRSNG HRS)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (PATIENT DAYS)	ALLIED HEALTH (ASSIGNED TIME)	
		13.00	15.00	16.00	17.00	23.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00101						1.00
2.00	00201						2.00
4.00	00400						4.00
5.01	00510						5.01
5.02	00511						5.02
5.03	00512						5.03
5.04	00513						5.04
5.05	00514						5.05
5.06	00560						5.06
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300	1,132,638					13.00
15.00	01500	0	100				15.00
16.00	01600	0	0	366,222,951			16.00
17.00	01700	0	0	0	26,494		17.00
23.00	02301	0	0	0	0	100	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	271,142	0	26,628,852	18,512	0	30.00
31.00	03100	53,841	0	5,838,789	2,252	0	31.00
41.00	04100	57,617	0	5,125,829	4,327	0	41.00
43.00	04300	13,878	0	3,536,736	1,403	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	138,925	0	46,300,160	0	0	50.00
51.00	05100	0	0	0	0	0	51.00
52.00	05200	52,523	0	10,351,863	0	0	52.00
53.00	05300	0	0	6,942,010	0	0	53.00
54.00	05400	122,874	0	75,002,421	0	100	54.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	4,651	0	6,837,942	0	0	59.00
60.00	06000	80,731	0	55,544,431	0	0	60.00
65.00	06500	50,175	0	10,185,813	0	0	65.00
66.00	06600	88,966	0	19,491,899	0	0	66.00
69.00	06900	40,423	0	13,894,239	0	0	69.00
71.00	07100	20,836	0	16,835,435	0	0	71.00
72.00	07200	0	0	5,272,030	0	0	72.00
73.00	07300	0	100	11,202,191	0	0	73.00
74.00	07400	0	0	248,240	0	0	74.00
76.00	03020	114	0	632,433	0	0	76.00
76.02	03022	11,498	0	10,290,922	0	0	76.02
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	9,874	0	5,991,075	0	0	90.00
91.00	09100	57,422	0	24,799,904	0	0	91.00
92.00	09200						92.00
92.01	09201	0	0	0	0	0	92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	47,679	0	5,269,737	0	0	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
118.00		1,123,169	100	366,222,951	26,494	100	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	9,469	0	0	0	0	194.01
194.04	07952	0	0	0	0	0	194.04
200.00							200.00
201.00							201.00
202.00		764,316	6,672,466	1,966,111	874,220	253,240	202.00
203.00		0.674810	66,724.660000	0.005369	32.996905	2,532.400000	203.00
204.00		90,864	178,260	109,524	99,110	30,698	204.00
205.00		0.080223	1,782.600000	0.000299	3.740847	306.980000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150010	Period: From 07/01/2011 To 06/30/2012	Worksheet C Part I Date/Time Prepared: 11/28/2012 1:28 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000 ADULTS & PEDIATRICS	14,907,745		14,907,745	0	14,907,745	30.00
31.00 03100 INTENSIVE CARE UNIT	3,599,486		3,599,486	0	3,599,486	31.00
41.00 04100 SUBPROVIDER - IRF	3,670,729		3,670,729	0	3,670,729	41.00
43.00 04300 NURSERY	974,661		974,661	0	974,661	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	14,003,726		14,003,726	0	14,003,726	50.00
51.00 05100 RECOVERY ROOM	0		0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	3,239,938		3,239,938	0	3,239,938	52.00
53.00 05300 ANESTHESIOLOGY	159,484		159,484	0	159,484	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	10,542,032		10,542,032	0	10,542,032	54.00
57.00 05700 CT SCAN	0		0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	713,840		713,840	0	713,840	59.00
60.00 06000 LABORATORY	8,872,715		8,872,715	0	8,872,715	60.00
65.00 06500 RESPIRATORY THERAPY	2,870,381	0	2,870,381	0	2,870,381	65.00
66.00 06600 PHYSICAL THERAPY	5,788,099	0	5,788,099	0	5,788,099	66.00
69.00 06900 ELECTROCARDIOLOGY	2,757,816		2,757,816	0	2,757,816	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4,781,684		4,781,684	0	4,781,684	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	3,870,129		3,870,129	0	3,870,129	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	7,230,059		7,230,059	0	7,230,059	73.00
74.00 07400 RENAL DIALYSIS	307,987		307,987	0	307,987	74.00
76.00 03020 PSYCH SERVICES	420,533		420,533	0	420,533	76.00
76.02 03022 ENDOSCOPY	952,273		952,273	0	952,273	76.02
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000 CLINIC	1,332,181		1,332,181	0	1,332,181	90.00
91.00 09100 EMERGENCY	5,027,484		5,027,484	0	5,027,484	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1,081,482		1,081,482	0	1,081,482	92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0		0	0	0	92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 09500 AMBULANCE SERVICES	1,864,792		1,864,792	0	1,864,792	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	0	98,969,256	0	98,969,256	200.00
201.00	Less Observation Beds	0	1,081,482	0	1,081,482	201.00
202.00	Total (see instructions)	0	97,887,774	0	97,887,774	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150010	Period: From 07/01/2011 To 06/30/2012	Worksheet C Part I Date/Time Prepared: 11/28/2012 1:28 pm
		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					
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000	ADULTS & PEDIATRICS	25,231,407		25,231,407	30.00
31.00	03100	INTENSIVE CARE UNIT	5,838,789		5,838,789	31.00
41.00	04100	SUBPROVIDER - IRF	5,125,829		5,125,829	41.00
43.00	04300	NURSERY	3,536,736		3,536,736	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	OPERATING ROOM	12,199,103	34,101,057	46,300,160	50.00
51.00	05100	RECOVERY ROOM	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,512,991	838,872	10,351,863	52.00
53.00	05300	ANESTHESIOLOGY	2,527,595	4,414,415	6,942,010	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,562,279	62,440,142	75,002,421	54.00
57.00	05700	CT SCAN	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	704,951	6,132,991	6,837,942	59.00
60.00	06000	LABORATORY	20,500,556	35,043,875	55,544,431	60.00
65.00	06500	RESPIRATORY THERAPY	7,061,141	3,124,672	10,185,813	65.00
66.00	06600	PHYSICAL THERAPY	8,379,951	11,111,948	19,491,899	66.00
69.00	06900	ELECTROCARDIOLOGY	3,797,528	10,096,711	13,894,239	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	14,770,266	2,065,169	16,835,435	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,547,598	724,432	5,272,030	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,279,981	3,922,210	11,202,191	73.00
74.00	07400	RENAL DIALYSIS	248,240	0	248,240	74.00
76.00	03020	PSYCH SERVICES	0	632,433	632,433	76.00
76.02	03022	ENDOSCOPY	211,615	10,079,307	10,290,922	76.02
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000	CLINIC	0	5,991,075	5,991,075	90.00
91.00	09100	EMERGENCY	5,024,086	19,775,818	24,799,904	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,397,445	1,397,445	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00	09500	AMBULANCE SERVICES	15,289	5,254,448	5,269,737	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)	149,075,931	217,147,020	366,222,951	200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)	149,075,931	217,147,020	366,222,951	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150010	Period: From 07/01/2011 To 06/30/2012	Worksheet C Part I Date/Time Prepared: 11/28/2012 1:28 pm
		Title XVII I	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		11.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
41.00	04100 SUBPROVIDER - IRF			41.00
43.00	04300 NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.302455		50.00
51.00	05100 RECOVERY ROOM	0.000000		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.312981		52.00
53.00	05300 ANESTHESIOLOGY	0.022974		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.140556		54.00
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.104394		59.00
60.00	06000 LABORATORY	0.159741		60.00
65.00	06500 RESPIRATORY THERAPY	0.281802		65.00
66.00	06600 PHYSICAL THERAPY	0.296949		66.00
69.00	06900 ELECTROCARDIOLOGY	0.198486		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.284025		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.734087		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.645415		73.00
74.00	07400 RENAL DIALYSIS	1.240682		74.00
76.00	03020 PSYCH SERVICES	0.664945		76.00
76.02	03022 ENDOSCOPY	0.092535		76.02
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000 CLINIC	0.222361		90.00
91.00	09100 EMERGENCY	0.202722		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.773900		92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0.000000		92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00	09500 AMBULANCE SERVICES	0.353868		95.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
113.00	11300 INTEREST EXPENSE			113.00
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: 150010

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

Worksheet C  
Part I  
Date/Time Prepared:  
11/28/2012 1:28 pm

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		
				Total Costs	RCE Disallowance	
		1.00	2.00	3.00	4.00	5.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000 ADULTS & PEDIATRICS	14,907,745		14,907,745	0	0 30.00
31.00	03100 INTENSIVE CARE UNIT	3,599,486		3,599,486	0	0 31.00
41.00	04100 SUBPROVIDER - IRF	3,670,729		3,670,729	0	0 41.00
43.00	04300 NURSERY	974,661		974,661	0	0 43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	14,003,726		14,003,726	0	0 50.00
51.00	05100 RECOVERY ROOM	0		0	0	0 51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	3,239,938		3,239,938	0	0 52.00
53.00	05300 ANESTHESIOLOGY	159,484		159,484	0	0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	10,542,032		10,542,032	0	0 54.00
57.00	05700 CT SCAN	0		0	0	0 57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0 58.00
59.00	05900 CARDIAC CATHETERIZATION	713,840		713,840	0	0 59.00
60.00	06000 LABORATORY	8,872,715		8,872,715	0	0 60.00
65.00	06500 RESPIRATORY THERAPY	2,870,381	0	2,870,381	0	0 65.00
66.00	06600 PHYSICAL THERAPY	5,788,099	0	5,788,099	0	0 66.00
69.00	06900 ELECTROCARDIOLOGY	2,757,816		2,757,816	0	0 69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4,781,684		4,781,684	0	0 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	3,870,129		3,870,129	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	7,230,059		7,230,059	0	0 73.00
74.00	07400 RENAL DIALYSIS	307,987		307,987	0	0 74.00
76.00	03020 PSYCH SERVICES	420,533		420,533	0	0 76.00
76.02	03022 ENDOSCOPY	952,273		952,273	0	0 76.02
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000 CLINIC	1,332,181		1,332,181	0	0 90.00
91.00	09100 EMERGENCY	5,027,484		5,027,484	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1,081,482		1,081,482	0	0 92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0		0	0	0 92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00	09500 AMBULANCE SERVICES	1,864,792		1,864,792	0	0 95.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00	11300 INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)	98,969,256	0	98,969,256	0	0 200.00
201.00	Less Observation Beds	1,081,482		1,081,482		0 201.00
202.00	Total (see instructions)	97,887,774	0	97,887,774	0	0 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150010

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

Worksheet C  
Part I  
Date/Time Prepared:  
11/28/2012 1:28 pm

		Title XIX			Hospital	Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	25,231,407		25,231,407		30.00
31.00	03100	INTENSIVE CARE UNIT	5,838,789		5,838,789		31.00
41.00	04100	SUBPROVIDER - IRF	5,125,829		5,125,829		41.00
43.00	04300	NURSERY	3,536,736		3,536,736		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	12,199,103	34,101,057	46,300,160	0.302455	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,512,991	838,872	10,351,863	0.312981	52.00
53.00	05300	ANESTHESIOLOGY	2,527,595	4,414,415	6,942,010	0.022974	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,562,279	62,440,142	75,002,421	0.140556	54.00
57.00	05700	CT SCAN	0	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	704,951	6,132,991	6,837,942	0.104394	59.00
60.00	06000	LABORATORY	20,500,556	35,043,875	55,544,431	0.159741	60.00
65.00	06500	RESPIRATORY THERAPY	7,061,141	3,124,672	10,185,813	0.281802	65.00
66.00	06600	PHYSICAL THERAPY	8,379,951	11,111,948	19,491,899	0.296949	66.00
69.00	06900	ELECTROCARDIOLOGY	3,797,528	10,096,711	13,894,239	0.198486	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	14,770,266	2,065,169	16,835,435	0.284025	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,547,598	724,432	5,272,030	0.734087	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,279,981	3,922,210	11,202,191	0.645415	73.00
74.00	07400	RENAL DIALYSIS	248,240	0	248,240	1.240682	74.00
76.00	03020	PSYCH SERVICES	0	632,433	632,433	0.664945	76.00
76.02	03022	ENDOSCOPY	211,615	10,079,307	10,290,922	0.092535	76.02
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	5,991,075	5,991,075	0.222361	90.00
91.00	09100	EMERGENCY	5,024,086	19,775,818	24,799,904	0.202722	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,397,445	1,397,445	0.773900	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0.000000	92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	15,289	5,254,448	5,269,737	0.353868	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	149,075,931	217,147,020	366,222,951		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	149,075,931	217,147,020	366,222,951		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150010	Period: From 07/01/2011 To 06/30/2012	Worksheet C Part I Date/Time Prepared: 11/28/2012 1:28 pm
		Title XIX	Hospital	Cost

Cost Center Description		PPS Inpatient Ratio		
		11.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
41.00	04100 SUBPROVIDER - IRF			41.00
43.00	04300 NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
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
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000 LABORATORY	0.000000		60.00
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
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
76.00	03020 PSYCH SERVICES	0.000000		76.00
76.02	03022 ENDOSCOPY	0.000000		76.02
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000 CLINIC	0.000000		90.00
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0.000000		92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00	09500 AMBULANCE SERVICES	0.000000		95.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
113.00	11300 INTEREST EXPENSE			113.00
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: 150010		Period: From 07/01/2011 To 06/30/2012		Worksheet D Part I Date/Time Prepared: 11/28/2012 1:28 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	1,370,228	0	1,370,228	19,960	68.65	30.00
31.00	03100 INTENSIVE CARE UNIT	259,899		259,899	2,252	115.41	31.00
41.00	04100 SUBPROVIDER - IRF	517,941	0	517,941	4,327	119.70	41.00
43.00	04300 NURSERY	71,300		71,300	1,403	50.82	43.00
200.00	Total (lines 30-199)	2,219,368		2,219,368	27,942		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 150010		Period: From 07/01/2011 To 06/30/2012		Worksheet D Part I Date/Time Prepared: 11/28/2012 1:28 pm	
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	Title XVIII		Hospital PPS	
		6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	8,230	564,990			30.00
31.00	03100	INTENSIVE CARE UNIT	1,429	164,921			31.00
41.00	04100	SUBPROVIDER - IRF	3,326	398,122			41.00
43.00	04300	NURSERY	0	0			43.00
200.00		Total (lines 30-199)	12,985	1,128,033			200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 150010	Period: From 07/01/2011 To 06/30/2012	Worksheet D Part II Date/Time Prepared: 11/28/2012 1:28 pm
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
Title VIII Hospital PPS							
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	1,291,385	46,300,160	0.027892	8,218,861	229,240	50.00
51.00	05100 RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	173,576	10,351,863	0.016768	11,622	195	52.00
53.00	05300 ANESTHESIOLOGY	13,989	6,942,010	0.002015	1,169,744	2,357	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	968,763	75,002,421	0.012916	7,406,374	95,661	54.00
57.00	05700 CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	29,714	6,837,942	0.004345	296,057	1,286	59.00
60.00	06000 LABORATORY	394,241	55,544,431	0.007098	11,334,203	80,450	60.00
65.00	06500 RESPIRATORY THERAPY	94,412	10,185,813	0.009269	4,685,894	43,434	65.00
66.00	06600 PHYSICAL THERAPY	451,742	19,491,899	0.023176	2,487,563	57,652	66.00
69.00	06900 ELECTROCARDIOLOGY	253,656	13,894,239	0.018256	3,249,947	59,331	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	202,084	16,835,435	0.012003	3,925,785	47,121	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	41,088	5,272,030	0.007794	4,504,185	35,106	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	190,472	11,202,191	0.017003	4,790,165	81,447	73.00
74.00	07400 RENAL DIALYSIS	4,024	248,240	0.016210	79,990	1,297	74.00
76.00	03020 PSYCH SERVICES	143,402	632,433	0.226747	0	0	76.00
76.02	03022 ENDOSCOPY	23,683	10,290,922	0.002301	0	0	76.02
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	111,824	5,991,075	0.018665	0	0	90.00
91.00	09100 EMERGENCY	681,396	24,799,904	0.027476	2,325,147	63,886	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	99,403	1,397,445	0.071132	0	0	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0.000000	0	0	92.01
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	5,168,854	321,220,453		54,485,537	798,463	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 150010		Period: From 07/01/2011 To 06/30/2012		Worksheet D Part III Date/Time Prepared: 11/28/2012 1:28 pm	
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Hospital Swing-Bed Adjustment Amount (see instructions)	PPS 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
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 150010		Period: From 07/01/2011 To 06/30/2012		Worksheet D Part III Date/Time Prepared: 11/28/2012 1:28 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)	PPS	
		6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	19,960	0.00	8,230	0		30.00
31.00	03100 INTENSIVE CARE UNIT	2,252	0.00	1,429	0		31.00
41.00	04100 SUBPROVIDER - IRF	4,327	0.00	3,326	0		41.00
43.00	04300 NURSERY	1,403	0.00	0	0		43.00
200.00	Total (lines 30-199)	27,942		12,985	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150010

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

Worksheet D  
Part IV  
Date/Time Prepared:  
11/28/2012 1:28 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		
<b>ANCILLARY SERVICE COST CENTERS</b>								
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	253,240	0	54.00	
57.00	05700	CT SCAN	0	0	0	0	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00	
60.00	06000	LABORATORY	0	0	0	0	60.00	
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00	
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00	
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	
76.00	03020	PSYCH SERVICES	0	0	0	0	76.00	
76.02	03022	ENDOSCOPY	0	0	0	0	76.02	
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	0	90.00	
91.00	09100	EMERGENCY	0	0	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00	
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	92.01	
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00	
200.00		Total (lines 50-199)	0	0	253,240	0	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150010

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

Worksheet D  
Part IV  
Date/Time Prepared:  
11/28/2012 1:28 pm

Cost Center Description		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)	Hospital		
					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	46,300,160	0.000000	0.000000	8,218,861	50.00
51.00	05100 RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	10,351,863	0.000000	0.000000	11,622	52.00
53.00	05300 ANESTHESIOLOGY	0	6,942,010	0.000000	0.000000	1,169,744	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	253,240	75,002,421	0.003376	0.003376	7,406,374	54.00
57.00	05700 CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	6,837,942	0.000000	0.000000	296,057	59.00
60.00	06000 LABORATORY	0	55,544,431	0.000000	0.000000	11,334,203	60.00
65.00	06500 RESPIRATORY THERAPY	0	10,185,813	0.000000	0.000000	4,685,894	65.00
66.00	06600 PHYSICAL THERAPY	0	19,491,899	0.000000	0.000000	2,487,563	66.00
69.00	06900 ELECTROCARDIOLOGY	0	13,894,239	0.000000	0.000000	3,249,947	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	16,835,435	0.000000	0.000000	3,925,785	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	5,272,030	0.000000	0.000000	4,504,185	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	11,202,191	0.000000	0.000000	4,790,165	73.00
74.00	07400 RENAL DIALYSIS	0	248,240	0.000000	0.000000	79,990	74.00
76.00	03020 PSYCH SERVICES	0	632,433	0.000000	0.000000	0	76.00
76.02	03022 ENDOSCOPY	0	10,290,922	0.000000	0.000000	0	76.02
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	5,991,075	0.000000	0.000000	0	90.00
91.00	09100 EMERGENCY	0	24,799,904	0.000000	0.000000	2,325,147	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1,397,445	0.000000	0.000000	0	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0.000000	0.000000	0	92.01
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	253,240	321,220,453			54,485,537	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150010

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

Worksheet D  
Part IV  
Date/Time Prepared:  
11/28/2012 1:28 pm

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		11.00	12.00	13.00	
Title XVII					
Hospital					
PPS					
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0	11,703,279	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	1,223,967	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	25,004	21,978,466	74,199	54.00
57.00	05700 CT SCAN	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	905,368	0	59.00
60.00	06000 LABORATORY	0	1,399,170	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	539,278	0	65.00
66.00	06600 PHYSICAL THERAPY	0	29,533	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	9,944,663	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,065,169	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	724,432	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	3,744,001	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	74.00
76.00	03020 PSYCH SERVICES	0	47,946	0	76.00
76.02	03022 ENDOSCOPY	0	0	0	76.02
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000 CLINIC	0	0	0	90.00
91.00	09100 EMERGENCY	0	5,574,284	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	371,955	0	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0	92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (lines 50-199)	25,004	60,251,511	74,199	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150010	Period: From 07/01/2011 To 06/30/2012	Worksheet D Part V Date/Time Prepared: 11/28/2012 1:28 pm
	Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges				
		PPS Reimbursed Services (see instructions)	Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)		
		1.00	2.00	3.00		
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	0.302455	11,703,279	0	0		50.00
51.00 05100 RECOVERY ROOM	0.000000	0	0	0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.312981	0	0	0		52.00
53.00 05300 ANESTHESIOLOGY	0.022974	1,223,967	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.140556	21,978,466	0	0		54.00
57.00 05700 CT SCAN	0.000000	0	0	0		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0.104394	905,368	0	0		59.00
60.00 06000 LABORATORY	0.159741	1,399,170	0	0		60.00
65.00 06500 RESPIRATORY THERAPY	0.281802	539,278	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0.296949	29,533	0	0		66.00
69.00 06900 ELECTROCARDIOLOGY	0.198486	9,944,663	0	0		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.284025	2,065,169	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.734087	724,432	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.645415	3,744,001	0	5,344		73.00
74.00 07400 RENAL DIALYSIS	1.240682	0	0	0		74.00
76.00 03020 PSYCH SERVICES	0.664945	47,946	0	0		76.00
76.02 03022 ENDOSCOPY	0.092535	0	0	0		76.02
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000 CLINIC	0.222361	0	0	0		90.00
91.00 09100 EMERGENCY	0.202722	5,574,284	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.773900	371,955	0	0		92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0.000000	0	0	0		92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 09500 AMBULANCE SERVICES	0.353868		0			95.00
200.00	Subtotal (see instructions)	60,251,511	0	5,344		200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges		0	0		201.00
202.00	Net Charges (line 200 +/- line 201)	60,251,511	0	5,344		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 150010	Period: From 07/01/2011 To 06/30/2012	Worksheet D Part V Date/Time Prepared: 11/28/2012 1:28 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Costs				
	PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)		
	5.00	6.00	7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	3,539,715	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	28,119	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	3,089,205	0	0	54.00
57.00	05700 CT SCAN	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	94,515	0	0	59.00
60.00	06000 LABORATORY	223,505	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	151,970	0	0	65.00
66.00	06600 PHYSICAL THERAPY	8,770	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	1,973,876	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	586,560	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	531,796	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2,416,434	0	3,449	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	74.00
76.00	03020 PSYCH SERVICES	31,881	0	0	76.00
76.02	03022 ENDOSCOPY	0	0	0	76.02
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000 CLINIC	0	0	0	90.00
91.00	09100 EMERGENCY	1,130,030	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	287,856	0	0	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0	92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500 AMBULANCE SERVICES		0		95.00
200.00	Subtotal (see instructions)	14,094,232	0	3,449	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges		0		201.00
202.00	Net Charges (line 200 +/- line 201)	14,094,232	0	3,449	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 150010 Component CCN: 15T010		Period: From 07/01/2011 To 06/30/2012		Worksheet D Part II Date/Time Prepared: 11/28/2012 1:28 pm	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 + col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	1,291,385	46,300,160	0.027892	78,979	2,203	50.00
51.00	05100 RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	173,576	10,351,863	0.016768	0	0	52.00
53.00	05300 ANESTHESIOLOGY	13,989	6,942,010	0.002015	6,340	13	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	968,763	75,002,421	0.012916	363,244	4,692	54.00
57.00	05700 CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	29,714	6,837,942	0.004345	0	0	59.00
60.00	06000 LABORATORY	394,241	55,544,431	0.007098	1,168,768	8,296	60.00
65.00	06500 RESPIRATORY THERAPY	94,412	10,185,813	0.009269	547,143	5,071	65.00
66.00	06600 PHYSICAL THERAPY	451,742	19,491,899	0.023176	3,698,728	85,722	66.00
69.00	06900 ELECTROCARDIOLOGY	253,656	13,894,239	0.018256	309,677	5,653	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	202,084	16,835,435	0.012003	435,715	5,230	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	41,088	5,272,030	0.007794	821	6	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	190,472	11,202,191	0.017003	550,191	9,355	73.00
74.00	07400 RENAL DIALYSIS	4,024	248,240	0.016210	31,126	505	74.00
76.00	03020 PSYCH SERVICES	143,402	632,433	0.226747	0	0	76.00
76.02	03022 ENDOSCOPY	23,683	10,290,922	0.002301	0	0	76.02
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	111,824	5,991,075	0.018665	0	0	90.00
91.00	09100 EMERGENCY	681,396	24,799,904	0.027476	9,279	255	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	99,403	1,397,445	0.071132	0	0	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0.000000	0	0	92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (Lines 50-199)	5,168,854	321,220,453		7,200,011	127,001	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150010 Component CCN: 15T010	Period: From 07/01/2011 To 06/30/2012	Worksheet D Part IV Date/Time Prepared: 11/28/2012 1:28 pm
	Title XVIII	Subprovider - IRF	PPS

Cost Center Description	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	
<b>ANCILLARY SERVICE COST CENTERS</b>						
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	253,240	0	253,240	54.00
57.00 05700 CT SCAN	0	0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000 LABORATORY	0	0	0	0	0	60.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
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
76.00 03020 PSYCH SERVICES	0	0	0	0	0	76.00
76.02 03022 ENDOSCOPY	0	0	0	0	0	76.02
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000 CLINIC	0	0	0	0	0	90.00
91.00 09100 EMERGENCY	0	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 09500 AMBULANCE SERVICES	0	0	253,240	0	253,240	95.00
200.00 Total (lines 50-199)	0	0	253,240	0	253,240	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150010 Component CCN: 15T010	Period: From 07/01/2011 To 06/30/2012	Worksheet D Part IV Date/Time Prepared: 11/28/2012 1:28 pm
		Title XVIII	Subprovider - IRF

Cost Center Description	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	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	0	46,300,160	0.000000	0.000000	78,979	50.00
51.00 05100 RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	10,351,863	0.000000	0.000000	0	52.00
53.00 05300 ANESTHESIOLOGY	0	6,942,010	0.000000	0.000000	6,340	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	253,240	75,002,421	0.003376	0.003376	363,244	54.00
57.00 05700 CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	6,837,942	0.000000	0.000000	0	59.00
60.00 06000 LABORATORY	0	55,544,431	0.000000	0.000000	1,168,768	60.00
65.00 06500 RESPIRATORY THERAPY	0	10,185,813	0.000000	0.000000	547,143	65.00
66.00 06600 PHYSICAL THERAPY	0	19,491,899	0.000000	0.000000	3,698,728	66.00
69.00 06900 ELECTROCARDIOLOGY	0	13,894,239	0.000000	0.000000	309,677	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	16,835,435	0.000000	0.000000	435,715	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	5,272,030	0.000000	0.000000	821	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	11,202,191	0.000000	0.000000	550,191	73.00
74.00 07400 RENAL DIALYSIS	0	248,240	0.000000	0.000000	31,126	74.00
76.00 03020 PSYCH SERVICES	0	632,433	0.000000	0.000000	0	76.00
76.02 03022 ENDOSCOPY	0	10,290,922	0.000000	0.000000	0	76.02
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000 CLINIC	0	5,991,075	0.000000	0.000000	0	90.00
91.00 09100 EMERGENCY	0	24,799,904	0.000000	0.000000	9,279	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1,397,445	0.000000	0.000000	0	92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0.000000	0.000000	0	92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 09500 AMBULANCE SERVICES						95.00
200.00 Total (Lines 50-199)	253,240	321,220,453			7,200,011	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150010  
Component CCN: 15T010

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

Worksheet D  
Part IV  
Date/Time Prepared:  
11/28/2012 1:28 pm  
PPS

Title XVII I

Subprovider -  
IRF

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		11.00	12.00	13.00	
<b>ANCILLARY SERVICE COST CENTERS</b>					
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	1,226	0	0	54.00
57.00	05700 CT SCAN	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	69.00
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
76.00	03020 PSYCH SERVICES	0	0	0	76.00
76.02	03022 ENDOSCOPY	0	0	0	76.02
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000 CLINIC	0	0	0	90.00
91.00	09100 EMERGENCY	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0	92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (Lines 50-199)	1,226	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150010	Period: From 07/01/2011 To 06/30/2012	Worksheet D-1 Date/Time Prepared: 11/28/2012 1:28 pm
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		19,960	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		19,960	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.		17,206	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		1,306	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)		8,230	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)		3,289	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
<b>SWING BED ADJUSTMENT</b>				
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)		14,907,745	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)		14,907,745	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed charges)		19,564,557	28.00
29.00	Private room charges (excluding swing-bed charges)		17,082,301	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		2,482,256	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.761977	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		992.81	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		1,900.66	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)		14,907,745	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		746.88	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		6,146,822	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)		6,146,822	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 150010	Period: From 07/01/2011 To 06/30/2012	Worksheet D-1 Date/Time Prepared: 11/28/2012 1:28 pm		
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)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	3,599,486	2,252	1,598.35	1,429	2,284,042	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)					16,186,772	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					24,617,636	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					729,911	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					823,467	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					1,553,378	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					23,064,258	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					1,448	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					746.88	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,081,482	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150010		Period: From 07/01/2011 To 06/30/2012		Worksheet D-1 Date/Time Prepared: 11/28/2012 1:28 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,370,228	14,907,745	0.091914	1,081,482	99,403	90.00
91.00	Nursing School cost	0	14,907,745	0.000000	1,081,482	0	91.00
92.00	Allied health cost	0	14,907,745	0.000000	1,081,482	0	92.00
93.00	All other Medical Education	0	14,907,745	0.000000	1,081,482	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150010	Period: From 07/01/2011 To 06/30/2012	Worksheet D-1
		Component CCN: 15T010		Date/Time Prepared: 11/28/2012 1:28 pm
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		4,327	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		4,327	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.		1,558	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		2,769	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)		3,326	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)		1,139	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
<b>SWING BED ADJUSTMENT</b>				
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)		3,670,729	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)		3,670,729	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed charges)		5,125,829	28.00
29.00	Private room charges (excluding swing-bed charges)		1,848,624	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		3,277,205	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.716124	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		1,186.54	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		1,183.53	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		3.01	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		2.16	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		3,365	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		3,667,364	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		848.33	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,821,546	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)		2,821,546	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150010		Period: From 07/01/2011 To 06/30/2012		Worksheet D-1	
		Component CCN: 15T010				Date/Time Prepared: 11/28/2012 1:28 pm	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	0	42.00
<b>Intensive Care Type Inpatient Hospital Units</b>							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	0	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
<b>Cost Center Description</b>							
					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					2,095,734		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					4,917,280		49.00
<b>PASS THROUGH COST ADJUSTMENTS</b>							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					398,122		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					128,227		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					526,349		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthesiologist, and medical education costs (line 49 minus line 52)					4,390,931		53.00
<b>TARGET AMOUNT AND LIMIT COMPUTATION</b>							
54.00 Program discharges					0		54.00
55.00 Target amount per discharge					0.00		55.00
56.00 Target amount (line 54 x line 55)					0		56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0		57.00
58.00 Bonus payment (see instructions)					0		58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00		59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00		60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0		61.00
62.00 Relief payment (see instructions)					0		62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0		63.00
<b>PROGRAM INPATIENT ROUTINE SWING BED COST</b>							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0		64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0		65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0		66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0		67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0		68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0		69.00
<b>PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY</b>							
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
<b>PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>							
87.00 Total observation bed days (see instructions)					0		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150010 Component CCN: 15T010		Period: From 07/01/2011 To 06/30/2012		Worksheet D-1 Date/Time Prepared: 11/28/2012 1:28 pm	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	517,941	3,670,729	0.141100	0	0	90.00
91.00	Nursing School cost	0	3,670,729	0.000000	0	0	91.00
92.00	Allied health cost	0	3,670,729	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,670,729	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150010	Period: From 07/01/2011 To 06/30/2012	Worksheet D-1 Date/Time Prepared: 11/28/2012 1:28 pm
Cost Center Description		Title XIX	Hospital	Cost
				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			19,960 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			19,960 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.			17,206 3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			1,306 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)			997 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)			1,403 15.00
16.00	Nursery days (title V or XIX only)			1,383 16.00
<b>SWING BED ADJUSTMENT</b>				
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)			14,907,745 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)			14,907,745 27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed charges)			25,403,346 28.00
29.00	Private room charges (excluding swing-bed charges)			22,180,293 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			3,223,053 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.586842 31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			1,289.10 32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			2,467.88 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)			14,907,745 37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			746.88 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			744,639 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)			744,639 41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 150010	Period: From 07/01/2011 To 06/30/2012	Worksheet D-1 Date/Time Prepared: 11/28/2012 1:28 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)	974,661	1,403	694.70	1,383	960,770	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	3,599,486	2,252	1,598.35	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					1,285,940	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,991,349	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					1,448	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					746.88	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,081,482	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150010		Period: From 07/01/2011 To 06/30/2012		Worksheet D-1 Date/Time Prepared: 11/28/2012 1:28 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150010	Period: From 07/01/2011 To 06/30/2012	Worksheet D-3 Date/Time Prepared: 11/28/2012 1:28 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		9,398,068	30.00
31.00	03100	INTENSIVE CARE UNIT		3,685,872	31.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.302455	8,218,861	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.312981	11,622	52.00
53.00	05300	ANESTHESIOLOGY	0.022974	1,169,744	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.140556	7,406,374	54.00
57.00	05700	CT SCAN	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.104394	296,057	59.00
60.00	06000	LABORATORY	0.159741	11,334,203	60.00
65.00	06500	RESPIRATORY THERAPY	0.281802	4,685,894	65.00
66.00	06600	PHYSICAL THERAPY	0.296949	2,487,563	66.00
69.00	06900	ELECTROCARDIOLOGY	0.198486	3,249,947	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.284025	3,925,785	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.734087	4,504,185	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.645415	4,790,165	73.00
74.00	07400	RENAL DIALYSIS	1.240682	79,990	74.00
76.00	03020	PSYCH SERVICES	0.664945	0	76.00
76.02	03022	ENDOSCOPY	0.092535	0	76.02
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0.222361	0	90.00
91.00	09100	EMERGENCY	0.202722	2,325,147	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.773900	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	0	92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50-94 and 96-98)		54,485,537	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net Charges (line 200 minus line 201)		54,485,537	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150010 Component CCN: 15T010	Period: From 07/01/2011 To 06/30/2012	Worksheet D-3 Date/Time Prepared: 11/28/2012 1:28 pm
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1.00	2.00	3.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS		0	30.00
31.00	03100 INTENSIVE CARE UNIT		0	31.00
41.00	04100 SUBPROVIDER - IRF		3,942,903	41.00
43.00	04300 NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.302455	78,979	50.00
51.00	05100 RECOVERY ROOM	0.000000	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.312981	0	52.00
53.00	05300 ANESTHESIOLOGY	0.022974	6,340	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.140556	363,244	54.00
57.00	05700 CT SCAN	0.000000	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.104394	0	59.00
60.00	06000 LABORATORY	0.159741	1,168,768	60.00
65.00	06500 RESPIRATORY THERAPY	0.281802	547,143	65.00
66.00	06600 PHYSICAL THERAPY	0.296949	3,698,728	66.00
69.00	06900 ELECTROCARDIOLOGY	0.198486	309,677	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.284025	435,715	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.734087	821	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.645415	550,191	73.00
74.00	07400 RENAL DIALYSIS	1.240682	31,126	74.00
76.00	03020 PSYCH SERVICES	0.664945	0	76.00
76.02	03022 ENDOSCOPY	0.092535	0	76.02
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000 CLINIC	0.222361	0	90.00
91.00	09100 EMERGENCY	0.202722	9,279	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.773900	0	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0.000000	0	92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00	09500 AMBULANCE SERVICES			95.00
200.00	Total (sum of lines 50-94 and 96-98)		7,200,011	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00	Net Charges (line 200 minus line 201)		7,200,011	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150010	Period: From 07/01/2011 To 06/30/2012	Worksheet D-3 Date/Time Prepared: 11/28/2012 1:28 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		998,016	30.00
31.00	03100	INTENSIVE CARE UNIT		833,552	31.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY		0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.302455	430,321	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.312981	330,797	52.00
53.00	05300	ANESTHESIOLOGY	0.022974	95,578	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.140556	512,571	54.00
57.00	05700	CT SCAN	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.104394	11,352	59.00
60.00	06000	LABORATORY	0.159741	1,082,561	60.00
65.00	06500	RESPIRATORY THERAPY	0.281802	403,412	65.00
66.00	06600	PHYSICAL THERAPY	0.296949	296,614	66.00
69.00	06900	ELECTROCARDIOLOGY	0.198486	237,904	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.284025	340,850	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.734087	42,592	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.645415	596,469	73.00
74.00	07400	RENAL DIALYSIS	1.240682	7,314	74.00
76.00	03020	PSYCH SERVICES	0.664945	0	76.00
76.02	03022	ENDOSCOPY	0.092535	0	76.02
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0.222361	0	90.00
91.00	09100	EMERGENCY	0.202722	161,782	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.773900	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	0	92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50-94 and 96-98)		4,550,117	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net Charges (line 200 minus line 201)		4,550,117	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150010 Component CCN: 15T010	Period: From 07/01/2011 To 06/30/2012	Worksheet D-3 Date/Time Prepared: 11/28/2012 1:28 pm
		Title XIX	Subprovider - IRF	Cost
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1.00	2.00	3.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
41.00	04100	SUBPROVIDER - IRF	54,235	41.00
43.00	04300	NURSERY	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000	OPERATING ROOM	0.302455	0 50.00
51.00	05100	RECOVERY ROOM	0.000000	0 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.312981	0 52.00
53.00	05300	ANESTHESIOLOGY	0.022974	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.140556	0 54.00
57.00	05700	CT SCAN	0.000000	0 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	0.104394	0 59.00
60.00	06000	LABORATORY	0.159741	3,698 591 60.00
65.00	06500	RESPIRATORY THERAPY	0.281802	0 65.00
66.00	06600	PHYSICAL THERAPY	0.296949	41,477 12,317 66.00
69.00	06900	ELECTROCARDIOLOGY	0.198486	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.284025	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.734087	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.645415	10,000 6,454 73.00
74.00	07400	RENAL DIALYSIS	1.240682	0 74.00
76.00	03020	PSYCH SERVICES	0.664945	0 76.00
76.02	03022	ENDOSCOPY	0.092535	0 76.02
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000	CLINIC	0.222361	0 90.00
91.00	09100	EMERGENCY	0.202722	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.773900	0 92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	0 92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00	09500	AMBULANCE SERVICES		0 95.00
200.00		Total (sum of lines 50-94 and 96-98)		55,175 19,362 200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0 201.00
202.00		Net Charges (line 200 minus line 201)		55,175 202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150010	Period: From 07/01/2011 To 06/30/2012	Worksheet E Part A Date/Time Prepared: 11/28/2012 1:28 pm
		Title XVIII	Hospital	PPS
			before 1/1	on/after 1/1
			1.00	1.01
<b>PART A - INPATIENT HOSPITAL SERVICES UNDER PPS</b>				
1.00	DRG Amounts Other than Outlier Payments		15,183,177	1.00
2.00	Outlier payments for discharges. (see instructions)		930,693	2.00
2.01	For inpatient PPS services rendered during the cost reporting period enter the operating outlier reconciliation amount for operating expenses from line 92.		0	2.01
3.00	Managed Care Simulated Payments		0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		145.04	4.00
<b>Indirect Medical Education Adjustment</b>				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(F)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(F)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 Federal Register, page 50069, August 1, 2002.		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
<b>Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA</b>				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (F)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment. (see instructions)		0.000000	27.00
28.00	IME Adjustment (see instructions)		0	28.00
29.00	Total IME payment ( sum of lines 22 and 28)		0	29.00
<b>Disproportionate Share Adjustment</b>				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		5.18	30.00
31.00	Percentage of Medicaid patient days to total days reported on Worksheet S-2, Part I, line 24. (see instructions)		21.42	31.00
32.00	Sum of lines 30 and 31		26.60	32.00
33.00	Allowable disproportionate share percentage (see instructions)		11.16	33.00
34.00	Disproportionate share adjustment (see instructions)		1,694,443	34.00
<b>Additional payment for high percentage of ESRD beneficiary discharges</b>				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		1,991	40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	41.00
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00	42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000	44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41)		0	46.00
47.00	Subtotal (see instructions)		17,808,313	47.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150010	Period: From 07/01/2011 To 06/30/2012	Worksheet E Part A Date/Time Prepared: 11/28/2012 1:28 pm
		Title XVII	Hospital	PPS
			before 1/1	on/after 1/1
			1.00	1.01
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0	48.00
49.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)		17,808,313	49.00
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)		1,337,258	50.00
51.00	Exception payment for inpatient program capital (Worksheet L, Part III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Worksheet E-4, line 49 see instructions).		0	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		0	54.00
55.00	Net organ acquisition cost (Worksheet D-4 Part III, col. 1, line 69)		0	55.00
56.00	Cost of teaching physicians (Worksheet D-5, Part II, col. 3, line 20)		0	56.00
57.00	Routine service other pass through costs		0	57.00
58.00	Ancillary service other pass through costs Worksheet D, Part IV, col. 11 line 200)		25,004	58.00
59.00	Total (sum of amounts on lines 49 through 58)		19,170,575	59.00
60.00	Primary payer payments		0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		19,170,575	61.00
62.00	Deductibles billed to program beneficiaries		1,596,463	62.00
63.00	Coinurance billed to program beneficiaries		53,257	63.00
64.00	Allowable bad debts (see instructions)		111,391	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		77,974	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		47,360	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		17,598,829	67.00
68.00	Credits received from manufacturers for replaced devices applicable to MS-DRG (see instructions)		0	68.00
69.00	Enter the time value of money for operating expenses, the capital outlier reconciliation amount and time value of money for capital related expenses by entering the sum of lines 93, 95 and 96. For SCH, if the hospital specific payment amount on line 48, is greater than the federal specific payment amount on line 47, do not complete this line.		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.95	Recovery of Accelerated Depreciation		0	70.95
70.96	Low Volume Payment-1		0	70.96
70.97	Low Volume Payment-2		0	70.97
70.98	Low Volume Payment-3		0	70.98
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		17,598,829	71.00
72.00	Interim payments		17,908,692	72.00
73.00	Tentative settlement (for contractor use only)		0	73.00
74.00	Balance due provider (Program) (line 71 minus the sum of lines 72 and 73)		-309,863	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-11, section 115.2		1,096,225	75.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
90.00	Operating outlier amount from Worksheet E, Part A line 2		0	90.00
91.00	Capital outlier from Worksheet L, Part I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the Time Value of Money		0.00	94.00
95.00	Time Value of Money for operating expenses(see instructions)		0	95.00
96.00	Time Value of Money for capital related expenses (see instructions)		0	96.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150010	Period: From 07/01/2011 To 06/30/2012	Worksheet E Part B Date/Time Prepared: 11/28/2012 1:28 pm
		Title XVII	Hospital	PPS
		1.00		
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		3,449	1.00
2.00	Medical and other services reimbursed under OPPI (see instructions)		14,020,033	2.00
3.00	PPS payments		10,600,409	3.00
4.00	Outlier payment (see instructions)		109,054	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.868	5.00
6.00	Line 2 times line 5		12,169,389	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		88.00	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		74,199	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		3,449	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges		5,344	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)		5,344	14.00
<b>Customary charges</b>				
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)		5,344	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		1,895	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)		3,449	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)		10,783,662	24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
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)		2,620,152	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)		8,166,959	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)		8,166,959	30.00
31.00	Primary payer payments		3,058	31.00
32.00	Subtotal (line 30 minus line 31)		8,163,901	32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Worksheet I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		188,554	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		131,988	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		83,941	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)		8,295,889	37.00
38.00	MSP-LCC reconciliation amount from PS&R		-213	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)		8,296,102	40.00
41.00	Interim payments		8,109,327	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)		186,775	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-11, section 115.2		0	44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
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: 150010 Component CCN: 15T010	Period: From 07/01/2011 To 06/30/2012	Worksheet E Part B Date/Time Prepared: 11/28/2012 1:28 pm
		Title XVII I	Subprovider - IRF	PPS
				1.00
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)			0 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			0 2.00
3.00	PPS payments			0 3.00
4.00	Outlier payment (see instructions)			0 4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000 5.00
6.00	Line 2 times line 5			0 6.00
7.00	Sum of line 3 plus line 4 divided by line 6			0.00 7.00
8.00	Transitional corridor payment (see instructions)			0 8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200			0 9.00
10.00	Organ acquisitions			0 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			0 11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
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
<b>Customary charges</b>				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR 413.13(e)			0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000 17.00
18.00	Total customary charges (see instructions)			0 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0 19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0 20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)			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
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
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
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
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. 15-11, section 115.2			0 44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 150010		Period: From 07/01/2011 To 06/30/2012		Worksheet E-1 Part I Date/Time Prepared: 11/28/2012 1:28 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		17,786,751		8,087,345	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER	03/15/2012	0	03/15/2012	21,982	3.01	
3.02		06/12/2012	139,259		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM	03/15/2012	17,318		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		121,941		21,982	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		17,908,692		8,109,327	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						5.00
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)						6.00
6.01	SETTLEMENT TO PROVIDER		0		186,775	6.01	
6.02	SETTLEMENT TO PROGRAM		309,863		0	6.02	
7.00	Total Medicare program liability (see instructions)		17,598,829		8,296,102	7.00	
				Contractor Number	Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor						8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 150010  
Component CCN: 15T010

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
11/28/2012 1:28 pm  
PPS

Title XVIII

Subprovider -  
IRF

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider					1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		4,177,636		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	03/15/2012	57,093		0	3.01
3.02		06/12/2012	13,815		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		70,908		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		4,248,544		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		59,478		0	6.02
7.00	Total Medicare program liability (see instructions)		4,189,066		0	7.00
				Contractor Number	Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150010 Component CCN: 15T010	Period: From 07/01/2011 To 06/30/2012	Worksheet E-3 Part III Date/Time Prepared: 11/28/2012 1:28 pm
		Title XVII	Subprovider - IRF	PPS
				1.00
<b>PART III - MEDICARE PART A SERVICES - IRF PPS</b>				
1.00	Net Federal PPS Payment (see instructions)			3,812,064 1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0173 2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			101,980 3.00
4.00	Outlier Payments			392,883 4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)			0.00 5.00
6.00	New Teaching program adjustment. (see instructions)			0.00 6.00
7.00	Current year's unweighted FTE count of I&R other than FTEs in the first 3 years of a "new teaching program". (see inst.)			0.00 7.00
8.00	Current year's unweighted I&R FTE count for residents within the first 3 years of a "new teaching program". (see inst.)			0.00 8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)			0.00 9.00
10.00	Average Daily Census (see instructions)			11.822404 10.00
11.00	Medical Education Adjustment Factor $\{((1 + (\text{line } 9/\text{line } 10)) \text{ raised to the power of } .6876 - 1)\}$ .			0.000000 11.00
12.00	Medical Education Adjustment (line 1 multiplied by line 11).			0 12.00
13.00	Total PPS Payment (sum of lines 1, 3, 4 and 12)			4,306,927 13.00
14.00	Nursing and Allied Health Managed Care payment (see instruction)			0 14.00
15.00	Organ acquisition			0 15.00
16.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)			0 16.00
17.00	Subtotal (see instructions)			4,306,927 17.00
18.00	Primary payer payments			0 18.00
19.00	Subtotal (line 17 less line 18).			4,306,927 19.00
20.00	Deductibles			43,400 20.00
21.00	Subtotal (line 19 minus line 20)			4,263,527 21.00
22.00	Coinurance			79,515 22.00
23.00	Subtotal (line 21 minus line 22)			4,184,012 23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			5,468 24.00
25.00	Adjusted reimbursable bad debts (see instructions)			3,828 25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			3,365 26.00
27.00	Subtotal (sum of lines 23 and 25)			4,187,840 27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 49)			0 28.00
29.00	Other pass through costs (see instructions)			1,226 29.00
30.00	Outlier payments reconciliation			0 30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 31.00
31.99	Recovery of Accelerated Depreciation			0 31.99
32.00	Total amount payable to the provider (see instructions)			4,189,066 32.00
33.00	Interim payments			4,248,544 33.00
34.00	Tentative settlement (for contractor use only)			0 34.00
35.00	Balance due provider/program (line 32 minus the sum lines 33 and 34)			-59,478 35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2			0 36.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
50.00	Original outlier amount from Worksheet E-3, Part III, line 4			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: 150010	Period: From 07/01/2011 To 06/30/2012	Worksheet E-3 Part VII Date/Time Prepared: 11/28/2012 1:28 pm
		Title XIX	Hospital	Cost
				1.00
<b>PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES</b>				
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>				
1.00	Inpatient hospital/SNF/NF services		2,991,349	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)		2,991,349	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)		2,991,349	7.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable Charges</b>				
8.00	Routine service charges		1,826,042	8.00
9.00	Ancillary service charges		4,550,117	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)		6,376,159	12.00
<b>CUSTOMARY CHARGES</b>				
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)		6,376,159	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		3,384,810	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)		2,991,349	21.00
<b>PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.</b>				
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.		2,991,349	29.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
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)		2,991,349	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)		2,991,349	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	37.00
38.00	Subtotal (line 36 ± line 37)		2,991,349	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)		2,991,349	40.00
41.00	Interim payments		2,991,349	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: 150010

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

Worksheet G

Date/Time Prepared:  
11/28/2012 1:28 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>CURRENT ASSETS</b>						
1.00	Cash on hand in banks	4,220,735	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	45,197,846	0	0	0	4.00
5.00	Other receivable	1,325,370	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-31,043,970	0	0	0	6.00
7.00	Inventory	1,707,200	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	5,296,826	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	26,704,007	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	1,422,671	0	0	0	12.00
13.00	Land improvements	2,293,313	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	66,796,747	0	0	0	15.00
16.00	Accumulated depreciation	-45,818,708	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	69,193,588	0	0	0	19.00
20.00	Accumulated depreciation	-58,969,276	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	34,918,335	0	0	0	30.00
<b>OTHER ASSETS</b>						
31.00	Investments	122,485,753	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	-3,591,382	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	118,894,371	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	180,516,713	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	3,269,905	0	0	0	37.00
38.00	Salaries, wages, and fees payable	6,923,509	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	132,425	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	5,422,370	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	15,748,209	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	16,799,140	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	1,610,819	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	18,409,959	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	34,158,168	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	146,358,545	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	146,358,545	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	180,516,713	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 150010

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

Worksheet G-1

Date/Time Prepared:  
11/28/2012 1:28 pm

		General Fund		Special Purpose Fund		
		1.00	2.00	3.00	4.00	
		1.00	Fund balances at beginning of period		136,072,531	
2.00	Net income (loss) (from Wkst. G-3, line 29)		16,030,114			2.00
3.00	Total (sum of line 1 and line 2)		152,102,645		0	3.00
4.00	Additions (credit adjustments) (specify)	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	Total additions (sum of line 4-9)		0		0	10.00
11.00	Subtotal (line 3 plus line 10)		152,102,645		0	11.00
12.00	ADJUSTMENTS	5,744,100		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	Total deductions (sum of lines 12-17)		5,744,100		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		146,358,545		0	19.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 150010

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

Worksheet G-1

Date/Time Prepared:  
11/28/2012 1:28 pm

		Endowment Fund		Plant Fund			
		5.00	6.00	7.00	8.00		
		1.00	Fund balances at beginning of period		0		
2.00	Net income (loss) (From Wkst. G-3, line 29)					2.00	
3.00	Total (sum of line 1 and line 2)		0		0	3.00	
4.00	Additions (credit adjustments) (specify)	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	Total additions (sum of line 4-9)		0		0	10.00	
11.00	Subtotal (line 3 plus line 10)		0		0	11.00	
12.00	ADJUSTMENTS	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	Total deductions (sum of lines 12-17)		0		0	18.00	
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		0		0	19.00	

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 150010

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

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
11/28/2012 1:28 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
General Inpatient Routine Services					
1.00	Hospital	19,564,557		19,564,557	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	5,125,829		5,125,829	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)	24,690,386		24,690,386	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	5,838,789		5,838,789	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)	5,838,789		5,838,789	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	30,529,175		30,529,175	17.00
18.00	Ancillary services	120,965,990		120,965,990	18.00
19.00	Outpatient services	0	209,458,050	209,458,050	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	15,289	5,254,448	5,269,737	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)	151,510,454	214,712,498	366,222,952	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		105,952,314		29.00
30.00	BAD DEBT	11,828,392			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)		11,828,392		36.00
37.00	TOTAL COLLECTION AGENCY FEES	592,015			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)		592,015		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		117,188,691		43.00

## STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 150010

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

Worksheet G-3

Date/Time Prepared:  
11/28/2012 1:28 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	366,222,952	1.00
2.00	Less contractual allowances and discounts on patients' accounts	233,802,804	2.00
3.00	Net patient revenues (line 1 minus line 2)	132,420,148	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	117,188,691	4.00
5.00	Net income from service to patients (line 3 minus line 4)	15,231,457	5.00
<b>OTHER INCOME</b>			
6.00	Contributions, donations, bequests, etc	622,264	6.00
7.00	Income from investments	5,486,900	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	0	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	39,760	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	510,771	22.00
23.00	Governmental appropriations	0	23.00
24.00	UNREALIZED LOSS	-7,797,877	24.00
24.01	INCOME FROM UNSOLIDATED ENTITIES	-4,408	24.01
24.02	OTHER NON-OPERATING GAINS	12,007	24.02
24.03	OTHER MISCELLANEOUS REVENUE	-1,372,585	24.03
24.04	GAIN ON SALE OF OTHER ASSETS	15,733	24.04
24.05	NET ASSETS RELEASED FROM RESTRICTION	56,570	24.05
25.00	Total other income (sum of lines 6-24)	-2,430,865	25.00
26.00	Total (line 5 plus line 25)	12,800,592	26.00
27.00	TOTAL NON-RECURRING EXPENSES	-3,229,522	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	-3,229,522	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	16,030,114	29.00

CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B

Provider CCN: 150010

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

Worksheet I-5

Date/Time Prepared:  
11/28/2012 1:28 pm

		1.00	
1.00	Total expenses related to care of program beneficiaries (see instructions)	0	1.00
2.00	Total payment (from Worksheet I-4, column 6, line 11)	0	2.00
3.00	Deductibles billed to Medicare (Part B) patients	0	3.00
4.00	Coinsurance billed to Medicare (Part B) patients	0	4.00
5.00	Bad debts for deductibles and coinsurance, net of bad debt recoveries	0	5.00
6.00			6.00
7.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	7.00
8.00	Net deductibles and coinsurance billed to Medicare (Part B) patients (sum of lines 3 and 4 less line 5)	0	8.00
9.00	Program payment (line 2 less line 3, times 80 percent)	0	9.00
10.00	Unrecovered from Medicare (Part B) patients (Line 1 minus the sum of lines 8 and 9. If negative, enter zero and do not complete line 11.)	0	10.00
11.00	Reimbursable bad debts (lesser of line 10 or line 5) (transfer to Worksheet E, Part B, line 33)	0	11.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 150010	Period: From 07/01/2011 To 06/30/2012	Worksheet L Parts I-III Date/Time Prepared: 11/28/2012 1:28 pm
		Title XVII	Hospital	PPS
				1.00
<b>PART I - FULLY PROSPECTIVE METHOD</b>				
<b>CAPITAL FEDERAL AMOUNT</b>				
1.00	Capital DRG other than outlier		1,219,602	1.00
2.00	Capital DRG outlier payments		50,212	2.00
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		56.73	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (line 1 times line 5)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		5.18	7.00
8.00	Percentage of Medicaid patient days to total days reported on Worksheet S-3, Part I (see instructions)		21.42	8.00
9.00	Sum of lines 7 and 8		26.60	9.00
10.00	Allowable disproportionate share percentage (see instructions)		5.53	10.00
11.00	Disproportionate share adjustment (line 1 times line 10)		67,444	11.00
12.00	Total prospective capital payments (sum of lines 1-2, 6, and 11)		1,337,258	12.00
				1.00
<b>PART II - PAYMENT UNDER REASONABLE COST</b>				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
				1.00
<b>PART III - COMPUTATION OF EXCEPTION PAYMENTS</b>				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00