

**ST. VINCENT DUNN HOSPITAL
BEDFORD, INDIANA**

PROVIDER NO. 15-1335 AND AIM NO. 100268040A

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

JUNE 30, 2012

ST. VINCENT DUNN HOSPITAL
PROVIDER NO. 15-1335 AND AIM NO. 100268040A

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Accountants' Disclaimer

Hospital Statements of Reimbursable Costs



Bradley Associates
Healthcare Advisors and CPAs

Board of Directors
St. Vincent Dunn Hospital
Bedford, Indiana

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

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

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

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

Bradley Associates

November 27, 2012

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 151335	Period: From 07/01/2011 To 06/30/2012	FORM APPROVED OMB NO. 0938-0050 Worksheet S Parts I-III Date/Time Prepared: 11/27/2012 11:29 am
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PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input checked="" type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 11/27/2012 Time: 11:29 am
Contractor use only	5. <input checked="" type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input 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 DUNN MEMORIAL HOSPITAL for the cost reporting period beginning 07/01/2011 and ending 06/30/2012 and to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services identified in this cost report were provided in compliance with such laws and regulations.

Encryption Information

ECR: Date: 11/27/2012 Time: 11:29 am
8wxik0kf7pudtjMnao3Fwkrk9iIBz0
67qzm0UnyRadeziRKNHHWLU0wRyh1l
.0co0g2t9s0Z4Iid
PI: Date: 11/27/2012 Time: 11:29 am
PayYePYfF89Jve0OrpJG7zWkqH3fx0
JOZ330YPLsv4NtGDvz41p6AlIrpbbw
JjomGamVYI0ZeBMX

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

Title

Date

	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	503,568	-400,653	0	0 1.00
2.00	Subprovider - IPF	0	0	0	0	0 2.00
3.00	Subprovider - IRF	0	0	0	0	0 3.00
4.00	SUBPROVIDER I	0	0	0	0	0 4.00
5.00	Swing bed - SNF	0	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	503,568	-400,653	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: 151335

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

Worksheet S-2
Part I
Date/Time Prepared:
11/26/2012 3:42 pm

		1.00	2.00	3.00	4.00					
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 1616 TWENTY-THIRD STREET	PO Box:		Zip Code: 47421		County: LAWRENCE			1.00	
2.00	City: BEDFORD	State: IN		Zip Code: 47421		County: LAWRENCE			2.00	
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
							V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
Hospital and Hospital-Based Component Identification:										
3.00	Hospital	DUNN MEMORIAL HOSPITAL	151335	99915	1	07/01/1966	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF						N	N	N	7.00
8.00	Swing Beds - NF						N	N	N	8.00
9.00	Hospital-Based SNF						N	N	N	9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA						N	N	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) 1									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00
						From:	To:			
						1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)					07/01/2011	06/30/2012			20.00
21.00	Type of Control (see instructions)					2				21.00
Inpatient PPS Information										
22.00	Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	N			22.00
23.00	Indicate in column 1 the method used to capture Medicaid (title XIX) days reported on lines 24 and/or 25 of this worksheet during the cost reporting period by entering a "1" if days are based on the date of admission, "2" if days are based on census days (also referred to as the day count), or "3" if the days are based on the date of discharge. Is the method of identifying the days in the current cost reporting period different from the method used in the prior cost reporting period? Enter in column 2 "Y" for yes or "N" for no.					2	N			23.00
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible days	Medicaid HMO days	Other Medicaid days			
		1.00	2.00	3.00	4.00	5.00	6.00			
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0			24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.	0	0	0	0	0	0			25.00
						Urban/Rural S	Date of Geogr			
						1.00	2.00			
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter (1) for urban or (2) for rural.					2				26.00
27.00	For the Standard Geographic classification (not wage), what is your status at the end of the cost reporting period. Enter (1) for urban or (2) for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					2				27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0				35.00
						Beginning:	Ending:			
						1.00	2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.									36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.					0				37.00
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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 151335

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

Worksheet S-2
Part I
Date/Time Prepared:
11/26/2012 3:42 pm

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

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		1.00	2.00	3.00		
Inpatient Psychiatric Facility PPS						
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00	
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			0	71.00	
Inpatient Rehabilitation Facility PPS						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00	
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			0	76.00	
		1.00				
Long Term Care Hospital PPS						
80.00	Are you a long term care hospital (LTCH)? Enter in column 1 "Y" for yes and "N" for no. LTCHs can only exist as independent/freestanding facilities. An independent or freestanding facility may exist as an unrelated hospital within a hospital, it must meet the separateness (from the host/co-located provider) requirements identified in 42 CFR 412.22(e.)		N		80.00	
TEFRA Providers						
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N		85.00	
86.00	Did this facility establish a new other subprovider (excluded unit) under 42 CFR section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		N		86.00	
		V		XIX		
		1.00		2.00		
Title V or XIX Inpatient Services						
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N		Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N		Y	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	92.00	
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N		N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N		N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.		0.00		95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.		0.00		97.00	
Rural Providers						
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	Y			105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N			106.00	
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N			107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N			108.00	
		Physical		Occupational		
		1.00		2.00		
		Speech		Respiratory		
		3.00		4.00		
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	109.00	
		1.00			2.00	
		3.00			4.00	
Miscellaneous Cost Reporting Information						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.	N		0	115.00	
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00	

		1.00	2.00	3.00	
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2			118.00
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	Enter the total amount of malpractice premiums paid in column 1, enter the total amount of paid losses in column 2, and enter the total amount of self insurance paid in column 3.	91,320	0	0	118.01
		1.00	2.00		
118.02	Indicate if malpractice premiums and paid losses are reported in other than the Administrative and General cost center. If yes, provide a supporting schedule and list the amounts applicable to each cost center.	N			118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	If this is an SCH (or EACH), regardless of bed size, or is rural hospital with 100 or fewer beds that qualifies for the outpatient hold harmless provision in accordance with ACA, section 3121, as amended by the Medicare and Medicaid Extenders Act (MMEA) of 2010, section 108; the Temporary Payroll Tax Cut Continuation Act of 2011, section 308; and the Middle Class Tax Relief and Job Creation Act of 2012, section 3002, enter "Y" for yes or "N" for no in column 1 or column 2, respectively. Note that for SCHs (and EACHs) the outpatient hold harmless provision is effective for services rendered from January 1, 2010 through February 29, 2012 regardless of bed size and from March 1, 2012 through December 31, 2012 to all SCHs (and EACHs) with 100 or fewer beds. These responses impact the TOPS calculation on worksheet E, Part B, line 8.	N	N		120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N			121.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	15H046		140.00
		1.00	2.00	3.00	
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.					
141.00	Name: ST. VINCENT HEALTH	Contractor's Name: WPS		Contractor's Number: 08101	141.00
142.00	Street: 10330 N. MERIDIAN ST.	PO Box:			142.00
143.00	City: INDIANAPOLIS	State: IN		Zip Code: 46290	143.00
		1.00	2.00		
144.00	Are provider based physicians' costs included in worksheet A?		Y		144.00
145.00	If costs for renal services are claimed on worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.		N		145.00
		1.00	2.00		
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N			146.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N			147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N			148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N			149.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151335		Period: From 07/01/2011 To 06/30/2012		Worksheet S-2 Part I Date/Time Prepared: 11/26/2012 3:42 pm		
		Part A	Part B	Title V	Title XIX			
		1.00	2.00	3.00	4.00			
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)								
155.00	Hospital	N	N	N	N		155.00	
156.00	Subprovider - IPF	N	N	N	N		156.00	
157.00	Subprovider - IRF	N	N	N	N		157.00	
158.00	SUBPROVIDER						158.00	
159.00	SNF	N	N	N	N		159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N		160.00	
161.00	CMHC		N	N	N		161.00	
						1.00		
Multicampus								
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00	166.00
						1.00		
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act								
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.						N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)							168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.00	169.00

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

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

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

Cost Center Description	Worksheet A	No. of Beds	Bed Days	CAH Hours	
	Line Number		Available		
	1.00	2.00	3.00	4.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	21	7,686	77,352.00	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)		21	7,686	77,352.00	7.00
8.00 INTENSIVE CARE UNIT	31.00	4	1,464	21,336.00	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)		25	9,150	98,688.00	14.00
15.00 CAH visits					15.00
16.00 SUBPROVIDER - IPF					16.00
17.00 SUBPROVIDER - IRF					17.00
18.00 SUBPROVIDER					18.00
19.00 SKILLED NURSING FACILITY	44.00	0	0		19.00
20.00 NURSING FACILITY					20.00
21.00 OTHER LONG TERM CARE					21.00
22.00 HOME HEALTH AGENCY	101.00				22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)					23.00
24.00 HOSPICE					24.00
25.00 CMHC - CMHC					25.00
26.00 RURAL HEALTH CLINIC					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER					26.25
27.00 Total (sum of lines 14-26)		25			27.00
28.00 Observation Bed Days					28.00
29.00 Ambulance Trips					29.00
30.00 Employee discount days (see instruction)					30.00
31.00 Employee discount days - IRF					31.00
32.00 Labor & delivery days (see instructions)					32.00
33.00 LTCH non-covered days					33.00

Cost Center Description	I/P Days / O/P Visits / Trips				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	1,974	92	3,223	1.00	
2.00 HMO		237	400		2.00	
3.00 HMO IPF		0	0		3.00	
4.00 HMO IRF		0	0		4.00	
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0	0	5.00	
6.00 Hospital Adults & Peds. Swing Bed NF	0	0	0	40	6.00	
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	0	1,974	92	3,263	7.00	
8.00 INTENSIVE CARE UNIT	0	605	18	889	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		14	517	13.00	
14.00 Total (see instructions)	0	2,579	124	4,669	14.00	
15.00 CAH visits	0	0	0	0	15.00	
16.00 SUBPROVIDER - IPF					16.00	
17.00 SUBPROVIDER - IRF					17.00	
18.00 SUBPROVIDER					18.00	
19.00 SKILLED NURSING FACILITY	0	0	0	0	19.00	
20.00 NURSING FACILITY					20.00	
21.00 OTHER LONG TERM CARE					21.00	
22.00 HOME HEALTH AGENCY	0	0	0	0	22.00	
23.00 AMBULATORY SURGICAL CENTER (D.P.)					23.00	
24.00 HOSPICE					24.00	
25.00 CMHC - CMHC					25.00	
26.00 RURAL HEALTH CLINIC					26.00	
26.25 FEDERALLY QUALIFIED HEALTH CENTER					26.25	
27.00 Total (sum of lines 14-26)					27.00	
28.00 Observation Bed Days	0		0	839	28.00	
29.00 Ambulance Trips		0			29.00	
30.00 Employee discount days (see instruction)				60	30.00	
31.00 Employee discount days - IRF				0	31.00	
32.00 Labor & delivery days (see instructions)			0	0	32.00	
33.00 LTCH non-covered days		0			33.00	

Cost Center Description	Full Time Equivalents			Discharges		
	Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	
	9.00	10.00	11.00	12.00	13.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)				0	626	1.00
2.00 HMO					58	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	234.39	0.00	0	626	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	0.00	0.00	0.00			19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00	0.00	0.00			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	234.39	0.00			27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

Cost Center Description	Discharges		
	Title XIX	Total All Patients	
	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	215	1,451	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)	215	1,451	14.00
15.00 CAH visits			15.00
16.00 SUBPROVIDER - IPF			16.00
17.00 SUBPROVIDER - IRF			17.00
18.00 SUBPROVIDER			18.00
19.00 SKILLED NURSING FACILITY			19.00
20.00 NURSING FACILITY			20.00
21.00 OTHER LONG TERM CARE			21.00
22.00 HOME HEALTH AGENCY			22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)			23.00
24.00 HOSPICE			24.00
25.00 CMHC - CMHC			25.00
26.00 RURAL HEALTH CLINIC			26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER			26.25
27.00 Total (sum of lines 14-26)			27.00
28.00 Observation Bed Days			28.00
29.00 Ambulance Trips			29.00
30.00 Employee discount days (see instruction)			30.00
31.00 Employee discount days - IRF			31.00
32.00 Labor & delivery days (see instructions)			32.00
33.00 LTCH non-covered days			33.00

		1.00	
Uncompensated and indigent care cost computation			
1.00	Cost to charge ratio (Worksheet C, Part I line 200 column 3 divided by line 200 column 8)	0.471642	1.00
Medicaid (see instructions for each line)			
2.00	Net revenue from Medicaid	7,287,650	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	13,388,550	6.00
7.00	Medicaid cost (line 1 times line 6)	6,314,602	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
State Children's Health Insurance Program (SCHIP) (see instructions for each line)			
9.00	Net revenue from stand-alone SCHIP	0	9.00
10.00	Stand-alone SCHIP charges	0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
Other state or local government indigent care program (see instructions for each line)			
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
Uncompensated care (see instructions for each line)			
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	280,936	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
		Uninsured patients	Insured patients
		1.00	2.00
		Total (col. 1 + col. 2)	3.00
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	2,146,752	0
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	1,012,498	0
22.00	Partial payment by patients approved for charity care	0	0
23.00	Cost of charity care (line 21 minus line 22)	1,012,498	0
		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	3,396,300	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	320,970	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)	3,075,330	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)	1,450,455	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)	2,462,953	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,462,953	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151335

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

Worksheet A

Date/Time Prepared:
11/26/2012 3:42 pm

Cost Center-Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100		874,670	874,670	-35,560	839,110	1.00
2.00	00200		893,078	893,078	0	893,078	2.00
4.00	00400	243,421	3,207,136	3,450,557	0	3,450,557	4.00
5.00	00500	1,705,470	3,128,343	4,833,813	35,560	4,869,373	5.00
7.00	00700	361,074	1,889,736	2,250,810	0	2,250,810	7.00
8.00	00800	7,847	69,891	77,738	0	77,738	8.00
9.00	00900	230,473	161,777	392,250	0	392,250	9.00
10.00	01000	243,747	387,095	630,842	-370,251	260,591	10.00
11.00	01100	0	0	0	370,251	370,251	11.00
13.00	01300	462,610	34,929	497,539	-223,060	274,479	13.00
14.00	01400	133,116	31,214	164,330	0	164,330	14.00
15.00	01500	451,662	1,045,227	1,496,889	0	1,496,889	15.00
16.00	01600	788,442	292,538	1,080,980	0	1,080,980	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	2,286,978	225,783	2,512,761	-410,070	2,102,691	30.00
31.00	03100	779,762	51,316	831,078	0	831,078	31.00
43.00	04300	0	0	0	188,959	188,959	43.00
44.00	04400	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	786,951	913,054	1,700,005	0	1,700,005	50.00
51.00	05100	0	0	0	0	0	51.00
52.00	05200	0	0	0	444,171	444,171	52.00
53.00	05300	0	13,613	13,613	0	13,613	53.00
54.00	05400	699,335	568,124	1,267,459	0	1,267,459	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	308,331	917,230	1,225,561	0	1,225,561	59.00
60.00	06000	379,323	1,683,627	2,062,950	0	2,062,950	60.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	429,937	41,403	471,340	0	471,340	65.00
66.00	06600	274,060	26,722	300,782	0	300,782	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	182,595	49,025	231,620	0	231,620	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
75.00	07500	0	0	0	0	0	75.00
75.01	07501	7,404	13,343	20,747	0	20,747	75.01
76.97	07697	75,562	725	76,287	0	76,287	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	830,216	785,765	1,615,981	0	1,615,981	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	0	0	0	95.00
101.00	10100	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
118.00		11,668,316	17,305,364	28,973,680	0	28,973,680	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
193.00	19300	0	0	0	0	0	193.00
194.00	07950	10,095	1,066	11,161	0	11,161	194.00
194.01	07951	39,332	1,120	40,452	0	40,452	194.01
194.02	07952	158,382	23,785	182,167	0	182,167	194.02
194.03	07953	118,843	49,833	168,676	0	168,676	194.03
194.04	07954	101,982	2,809	104,791	0	104,791	194.04
194.05	07955	0	0	0	0	0	194.05
194.06	07956	0	31,989	31,989	0	31,989	194.06
200.00		12,096,950	17,415,966	29,512,916	0	29,512,916	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151335

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

Worksheet A
Date/Time Prepared:
11/26/2012 3:42 pm

Cost Center Description		Adjustments (See A-8) 6.00	Net Expenses For Allocation 7.00		
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	298,826	1,137,936	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	893,078	2.00
4.00	00400	EMPLOYEE BENEFITS	141,577	3,592,134	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	461,545	5,330,918	5.00
7.00	00700	OPERATION OF PLANT	-36,150	2,214,660	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	77,738	8.00
9.00	00900	HOUSEKEEPING	0	392,250	9.00
10.00	01000	DIETARY	0	260,591	10.00
11.00	01100	CAFETERIA	-91,097	279,154	11.00
13.00	01300	NURSING ADMINISTRATION	-261	274,218	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	164,330	14.00
15.00	01500	PHARMACY	-8,244	1,488,645	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-23,223	1,057,757	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-1,190	2,101,501	30.00
31.00	03100	INTENSIVE CARE UNIT	0	831,078	31.00
43.00	04300	NURSERY	0	188,959	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	1,700,005	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	444,171	52.00
53.00	05300	ANESTHESIOLOGY	0	13,613	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,267,459	54.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,225,561	59.00
60.00	06000	LABORATORY	-8,887	2,054,063	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	471,340	65.00
66.00	06600	PHYSICAL THERAPY	-2,860	297,922	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	-41,567	190,053	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	75.00
75.01	07501	SLEEP DISORDER	0	20,747	75.01
76.97	07697	CARDIAC REHABILITATION	0	76,287	76.97
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0	1,615,981	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	101.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	688,469	29,662,149	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
194.00	07950	MARKETING	418,262	429,423	194.00
194.01	07951	FOUNDATION	0	40,452	194.01
194.02	07952	COMMUNITY OUTREACH	0	182,167	194.02
194.03	07953	WIC	0	168,676	194.03
194.04	07954	GRANTS	0	104,791	194.04
194.05	07955	VACANT SPACE	0	0	194.05
194.06	07956	OLD AMBULANCE CENTER	0	31,989	194.06
200.00		TOTAL (SUM OF LINES 118-199)	1,106,731	30,619,647	200.00

Provider CCN: 151335

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

Worksheet A-6

Date/Time Prepared:
11/26/2012 3:42 pm

	Increases				
	Cost Center 2.00	Line # 3.00	Salary 4.00	Other 5.00	
	A - CAFETERIA				
1.00	CAFETERIA	11.00	143,059	227,192	1.00
	TOTALS		143,059	227,192	
	B - INTEREST EXPENSE				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	35,560	1.00
	TOTALS		0	35,560	
	C - NURSERY AND OB				
1.00	NURSERY	43.00	174,045	14,914	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	409,113	35,058	2.00
	TOTALS		583,158	49,972	
	D - MED SURG ASSOCIATES				
1.00	ADULTS & PEDIATRICS	30.00	223,060	0	1.00
	TOTALS		223,060	0	
500.00	Grand Total: Increases		949,277	312,724	500.00

Provider CCN: 151335

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

Worksheet A-6

Date/Time Prepared:
11/26/2012 3:42 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA						
1.00	DIETARY	10.00	143,059	227,192	0		1.00
	TOTALS		143,059	227,192			
	B - INTEREST EXPENSE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	35,560	9		1.00
	TOTALS		0	35,560			
	C - NURSERY AND OB						
1.00	ADULTS & PEDIATRICS	30.00	583,158	49,972	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		583,158	49,972			
	D - MED SURG ASSOCIATES						
1.00	NURSING ADMINISTRATION	13.00	223,060	0	0		1.00
	TOTALS		223,060	0			
500.00	Grand Total: Decreases		949,277	312,724			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151335

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
11/26/2012 3:42 pm

	Beginning Balances	Acquisitions			Disposals and Retirements		
		Purchases	Donation	Total			
		1.00	2.00	3.00			4.00
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	0	100,000	0	100,000	0	1.00
2.00	Land Improvements	0	60,000	0	60,000	0	2.00
3.00	Buildings and Fixtures	0	5,495,328	368,288	5,863,616	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	3,599,153	0	3,599,153	2,558,373	5.00
6.00	Movable Equipment	0	0	2,658,400	2,658,400	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	0	9,254,481	3,026,688	12,281,169	2,558,373	8.00
9.00	Reconciling Items	0	0	368,288	368,288	0	9.00
10.00	Total (line 8 minus line 9)	0	9,254,481	2,658,400	11,912,881	2,558,373	10.00
SUMMARY OF CAPITAL							
Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)		
	9.00	10.00	11.00	12.00	13.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	537,221	0	293,188	44,260	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	749,205	0	0	17,609	0	2.00
3.00	Total (sum of lines 1-2)	1,286,426	0	293,188	61,869	0	3.00
COMPUTATION OF RATIOS							
Cost Center Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL Ratio (see instructions)	Insurance		
	1.00	2.00	3.00	4.00	5.00		
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	7,064,396	0	7,064,396	0.726581	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,658,400	0	2,658,400	0.273419	0	2.00
3.00	Total (sum of lines 1-2)	9,722,796	0	9,722,796	1.000000	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151335

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
11/26/2012 3:42 pm

		Ending Balance	Fully Depreciated Assets			
		6.00	7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	100,000	0		1.00	
2.00	Land Improvements	60,000	0		2.00	
3.00	Buildings and Fixtures	5,863,616	0		3.00	
4.00	Building Improvements	0	0		4.00	
5.00	Fixed Equipment	1,040,780	0		5.00	
6.00	Movable Equipment	2,658,400	0		6.00	
7.00	HIT designated Assets	0	0		7.00	
8.00	Subtotal (sum of lines 1-7)	9,722,796	0		8.00	
9.00	Reconciling Items	368,288	0		9.00	
10.00	Total (line 8 minus line 9)	9,354,508	0		10.00	
SUMMARY OF CAPITAL						
Cost Center Description		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)			
		14.00	15.00			
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1	874,670		1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	126,264	893,078		2.00	
3.00	Total (sum of lines 1-2)	126,265	1,767,748		3.00	
ALLOCATION OF OTHER CAPITAL						
Cost Center Description		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL Depreciation	Lease
		6.00	7.00	8.00	9.00	10.00
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	800,487	0
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	749,205	0
3.00	Total (sum of lines 1-2)	0	0	0	1,549,692	0

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151335

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
11/26/2012 3:42 pm

Cost Center Description	SUMMARY OF CAPITAL					
	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
	11.00	12.00	13.00	14.00	15.00	
PART III -- RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00 CAP REL COSTS-BLDG & FIXT	293,188	44,260	0	1	1,137,936	1.00
2.00 CAP REL COSTS-MVBLE EQUIP	0	17,609	0	126,264	893,078	2.00
3.00 Total (sum of lines 1-2)	293,188	61,869	0	126,265	2,031,014	3.00

Line #	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted	
				Cost Center	Line #
		1.00	2.00	3.00	4.00
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-40,538	CAP REL COSTS-BLDG & FIXT	1.00 1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00 2.00
3.00	Investment income - other (chapter 2)	B	-5,595	ADMINISTRATIVE & GENERAL	5.00 3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00 4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00 5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00 6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-2,965	OPERATION OF PLANT	7.00 7.00
8.00	Television and radio service (chapter 21)		0		0.00 8.00
9.00	Parking lot (chapter 21)		0		0.00 9.00
10.00	Provider-based physician adjustment	A-8-2	-41,867		10.00 10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00 11.00
12.00	Related organization transactions (chapter 10)	A-8-1	1,589,883		12.00 12.00
13.00	Laundry and linen service		0		0.00 13.00
14.00	Cafeteria-employees and guests	B	-91,097	CAFETERIA	11.00 14.00
15.00	Rental of quarters to employee and others		0		0.00 15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00 16.00
17.00	Sale of drugs to other than patients		0		0.00 17.00
18.00	Sale of medical records and abstracts	B	-23,223	MEDICAL RECORDS & LIBRARY	16.00 18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00 19.00
20.00	Vending machines		0		0.00 20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00 21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00 22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00 23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00 24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00 25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00 26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00 27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00 28.00
29.00	Physicians' assistant		0		0.00 29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00 30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00 31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00 32.00
33.00	PHYSICIAN RECRUITMENT	A	-20,092	ADMINISTRATIVE & GENERAL	5.00 33.00
33.01	ENTERTAINMENT	A	-127	ADMINISTRATIVE & GENERAL	5.00 33.01
33.02	ENTERTAINMENT	A	-28	LABORATORY	60.00 33.02
33.03	DONATION EXPENSE	A	-150	ADMINISTRATIVE & GENERAL	5.00 33.03
33.04	LOSS ON FIXED ASSETS	A	-7,284	LABORATORY	60.00 33.04
33.05	RENTAL INCOME	B	-100,117	OPERATION OF PLANT	7.00 33.05
33.06	LOBBYING OFFSET	A	-851	ADMINISTRATIVE & GENERAL	5.00 33.06
33.07	MISC REVENUE	B	-890	ADULTS & PEDIATRICS	30.00 33.07
33.08	MISC REVENUE	B	-1,575	LABORATORY	60.00 33.08
33.09	MISC REVENUE	B	-8,244	PHARMACY	15.00 33.09
33.10	MISC REVENUE	B	-2,860	PHYSICAL THERAPY	66.00 33.10
33.11	MISC REVENUE	B	-55,926	ADMINISTRATIVE & GENERAL	5.00 33.11
33.12	MISC REVENUE	B	-261	NURSING ADMINISTRATION	13.00 33.12
33.13	INCENTIVE PAYROLL - SALARY	A	-77,228	ADMINISTRATIVE & GENERAL	5.00 33.13
33.14	INCENTIVE PAYROLL - FICA	A	-2,234	EMPLOYEE BENEFITS	4.00 33.14
33.15			0		0.00 33.15
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		1,106,731		50.00

Cost Center Description	Wkst. A-7 Ref.	
	5.00	
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	9	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	0	2.00
3.00 Investment income - other (chapter 2)	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)	0	7.00
8.00 Television and radio service (chapter 21)	0	8.00
9.00 Parking lot (chapter 21)	0	9.00
10.00 Provider-based physician adjustment	0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)	0	11.00
12.00 Related organization transactions (chapter 10)	0	12.00
13.00 Laundry and linen service	0	13.00
14.00 Cafeteria-employees and guests	0	14.00
15.00 Rental of quarters to employee and others	0	15.00
16.00 Sale of medical and surgical supplies to other than patients	0	16.00
17.00 Sale of drugs to other than patients	0	17.00
18.00 Sale of medical records and abstracts	0	18.00
19.00 Nursing school (tuition, fees, books, etc.)	0	19.00
20.00 Vending machines	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)		24.00
25.00 Utilization review - physicians' compensation (chapter 21)		25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT	0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP	0	27.00
28.00 Non-physician Anesthetist		28.00
29.00 Physicians' assistant	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)		30.00
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest	0	32.00
33.00 PHYSICIAN RECRUITMENT	0	33.00
33.01 ENTERTAINMENT	0	33.01
33.02 ENTERTAINMENT	0	33.02
33.03 DONATION EXPENSE	0	33.03
33.04 LOSS ON FIXED ASSETS	0	33.04
33.05 RENTAL INCOME	0	33.05
33.06 LOBBYING OFFSET	0	33.06
33.07 MISC REVENUE	0	33.07
33.08 MISC REVENUE	0	33.08
33.09 MISC REVENUE	0	33.09
33.10 MISC REVENUE	0	33.10
33.11 MISC REVENUE	0	33.11
33.12 MISC REVENUE	0	33.12
33.13 INCENTIVE PAYROLL - SALARY	0	33.13
33.14 INCENTIVE PAYROLL - FICA	0	33.14
33.15	0	33.15
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: 151335

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

Worksheet A-8-1

Date/Time Prepared: 11/26/2012 3:42 pm

		Line No.	Cost Center	Expense Items	
		1.00	2.00	3.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED					
HOME OFFICE COSTS:					
1.00		1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE	1.00
2.00		4.00	EMPLOYEE BENEFITS	HOME OFFICE	2.00
3.00		5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	3.00
4.00		194.00	MARKETING	HOME OFFICE	4.00
4.01		4.00	EMPLOYEE BENEFITS	SELF INSURANCE	4.01
4.02		4.00	EMPLOYEE BENEFITS	ST VINCENT HLTH CHARGEBACK	4.02
4.03		5.00	ADMINISTRATIVE & GENERAL	ST VINCENT HLTH CHARGEBACK	4.03
4.04		7.00	OPERATION OF PLANT	ST VINCENT HLTH CHARGEBACK	4.04
4.05		13.00	NURSING ADMINISTRATION	ST VINCENT HLTH CHARGEBACK	4.05
4.06		14.00	CENTRAL SERVICES & SUPPLY	ST VINCENT HLTH CHARGEBACK	4.06
4.07		16.00	MEDICAL RECORDS & LIBRARY	ST VINCENT HLTH CHARGEBACK	4.07
4.08		54.00	RADIOLOGY-DIAGNOSTIC	ST VINCENT HLTH CHARGEBACK	4.08
4.09		60.00	LABORATORY	ST VINCENT HLTH CHARGEBACK	4.09
4.10		66.00	PHYSICAL THERAPY	ST VINCENT HLTH CHARGEBACK	4.10
4.11		69.00	ELECTROCARDIOLOGY	ST VINCENT HLTH CHARGEBACK	4.11
4.12		194.02	COMMUNITY OUTREACH	ST VINCENT HLTH CHARGEBACK	4.12
4.13		7.00	OPERATION OF PLANT	ASCENSION MAINTENANCE	4.13
4.14		1.00	CAP REL COSTS-BLDG & FIXT	ASCENSION INTEREST	4.14
4.15		5.00	ADMINISTRATIVE & GENERAL	ASCENSION INTEREST	4.15
4.16		4.00	EMPLOYEE BENEFITS	PENSION	4.16
4.17		0.00			4.17
4.18		0.00			4.18
4.19		0.00			4.19
4.20		0.00			4.20
4.21		0.00			4.21
4.22		0.00			4.22
4.23		0.00			4.23
4.24		0.00			4.24
4.25		0.00			4.25
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to worksheet A-8, column 2, line 12.				5.00

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

Symbol (1)	Name	Percentage of Ownership
1.00	2.00	3.00

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

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

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

6.00		B	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:		0.00	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: 151335

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

Worksheet A-8-1

Date/Time Prepared: 11/26/2012 3:42 pm

	Amount of Allowable Cost	Amount Included in wks. A, column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	4.00	5.00	6.00	7.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	368,713	0	368,713	9	1.00
2.00	0	86,525	-86,525	0	2.00
3.00	2,094,483	1,468,918	625,565	0	3.00
4.00	418,262	0	418,262	0	4.00
4.01	1,860,152	1,629,816	230,336	0	4.01
4.02	36,451	36,451	0	0	4.02
4.03	35,340	35,340	0	0	4.03
4.04	197,155	197,155	0	0	4.04
4.05	925	925	0	0	4.05
4.06	46,314	46,314	0	0	4.06
4.07	16,080	16,080	0	0	4.07
4.08	7,445	7,445	0	0	4.08
4.09	100	100	0	0	4.09
4.10	67,272	67,272	0	0	4.10
4.11	16,517	16,517	0	0	4.11
4.12	15,039	15,039	0	0	4.12
4.13	676,129	609,197	66,932	0	4.13
4.14	228,279	257,628	-29,349	9	4.14
4.15	31,509	35,560	-4,051	0	4.15
4.16	169,175	169,175	0	0	4.16
4.17	0	0	0	0	4.17
4.18	0	0	0	0	4.18
4.19	0	0	0	0	4.19
4.20	0	0	0	0	4.20
4.21	0	0	0	0	4.21
4.22	0	0	0	0	4.22
4.23	0	0	0	0	4.23
4.24	0	0	0	0	4.24
4.25	0	0	0	0	4.25
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to worksheet A-8, column 2, line 12.	6,285,340	4,695,457	1,589,883	5.00

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151335

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

Worksheet A-8-2

Date/Time Prepared:
11/26/2012 3:42 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
	1.00	2.00	3.00	4.00	
1.00	13.00	NURSING ADMINISTRATION	4,650	0	1.00
2.00	15.00	PHARMACY	102	0	2.00
3.00	31.00	INTENSIVE CARE UNIT	12,110	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	50,000	0	4.00
5.00	59.00	CARDIAC CATHETERIZATION	52,493	0	5.00
6.00	60.00	LABORATORY	33,500	0	6.00
7.00	69.00	ELECTROCARDIOLOGY	41,567	41,567	7.00
8.00	91.00	EMERGENCY	693,558	0	8.00
9.00	30.00	ADULTS & PEDIATRICS	300	300	9.00
10.00	0.00		0	0	10.00
200.00			888,280	41,867	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151335

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

Worksheet A-8-2

Date/Time Prepared:
11/26/2012 3:42 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	4,650	0	0	0	0	1.00
2.00	102	0	0	0	0	2.00
3.00	12,110	0	0	0	0	3.00
4.00	50,000	0	0	0	0	4.00
5.00	52,493	0	0	0	0	5.00
6.00	33,500	0	0	0	0	6.00
7.00	0	0	0	0	0	7.00
8.00	693,558	0	0	0	0	8.00
9.00	0	0	0	0	0	9.00
10.00	0	0	0	0	0	10.00
200.00	846,413					200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151335

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

Worksheet A-8-2

Date/Time Prepared:
11/26/2012 3:42 pm

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151335

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

Worksheet A-8-2

Date/Time Prepared:
11/26/2012 3:42 pm

	RCE Disallowance	Adjustment	
	17.00	18.00	
1.00	0	0	1.00
2.00	0	0	2.00
3.00	0	0	3.00
4.00	0	0	4.00
5.00	0	0	5.00
6.00	0	0	6.00
7.00	0	41,567	7.00
8.00	0	0	8.00
9.00	0	300	9.00
10.00	0	0	10.00
200.00	0	41,867	200.00

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS	Subtotal	
		BLDG & FIXT	MVBLE EQUIP				
		1.00	2.00	4.00			
GENERAL SERVICE COST CENTERS							
1.00 00100	CAP REL COSTS-BLDG & FIXT	1,137,936	1,137,936				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	893,078		893,078			2.00
4.00 00400	EMPLOYEE BENEFITS	3,592,134	37,678	29,571	3,659,383		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	5,330,918	159,913	125,502	526,508	6,142,841	5.00
7.00 00700	OPERATION OF PLANT	2,214,660	118,072	92,666	111,470	2,536,868	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	77,738	19,933	15,644	2,423	115,738	8.00
9.00 00900	HOUSEKEEPING	392,250	19,182	15,054	71,151	497,637	9.00
10.00 01000	DIETARY	260,591	16,404	12,874	31,084	320,953	10.00
11.00 01100	CAFETERIA	279,154	42,417	33,290	44,165	399,026	11.00
13.00 01300	NURSING ADMINISTRATION	274,218	9,591	7,527	73,953	365,289	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	164,330	24,177	18,975	41,095	248,577	14.00
15.00 01500	PHARMACY	1,488,645	15,057	11,817	139,436	1,654,955	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	1,057,757	45,130	35,419	243,405	1,381,711	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	2,101,501	72,233	56,690	594,857	2,825,281	30.00
31.00 03100	INTENSIVE CARE UNIT	831,078	24,940	19,574	240,726	1,116,318	31.00
43.00 04300	NURSERY	188,959	4,477	3,513	53,731	250,680	43.00
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	1,700,005	82,271	64,569	242,945	2,089,790	50.00
51.00 05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	444,171	61,653	48,387	126,300	680,511	52.00
53.00 05300	ANESTHESIOLOGY	13,613	2,247	1,764	0	17,624	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,267,459	54,941	43,119	215,897	1,581,416	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	1,225,561	23,372	18,343	95,187	1,362,463	59.00
60.00 06000	LABORATORY	2,054,063	44,778	35,143	117,103	2,251,087	60.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	471,340	13,513	10,605	132,729	628,187	65.00
66.00 06600	PHYSICAL THERAPY	297,922	25,882	20,313	84,607	428,724	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY	190,053	16,923	13,281	56,370	276,627	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00 07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01 07501	SLEEP DISORDER	20,747	2,933	2,302	2,286	28,268	75.01
76.97 07697	CARDIAC REHABILITATION	76,287	8,005	6,283	23,327	113,902	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00 09100	EMERGENCY	1,615,981	35,205	27,629	256,302	1,935,117	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00 09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00 10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	29,662,149	980,927	769,854	3,527,057	29,249,590	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,726	2,924	0	6,650	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	110,872	87,015	0	197,887	192.00
193.00 19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00 07950	MARKETING	429,423	1,955	1,534	3,116	436,028	194.00
194.01 07951	FOUNDATION	40,452	1,204	945	12,142	54,743	194.01
194.02 07952	COMMUNITY OUTREACH	182,167	10,509	8,248	48,895	249,819	194.02
194.03 07953	WIC	168,676	9,984	7,836	36,689	223,185	194.03
194.04 07954	GRANTS	104,791	5,776	4,533	31,484	146,584	194.04
194.05 07955	VACANT SPACE	0	12,983	10,189	0	23,172	194.05
194.06 07956	OLD AMBULANCE CENTER	31,989	0	0	0	31,989	194.06
200.00	Cross Foot Adjustments	0	0	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	30,619,647	1,137,936	893,078	3,659,383	30,619,647	202.00

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500	6,142,841					5.00
7.00	00700	636,668	3,173,536				7.00
8.00	00800	29,046	78,165	222,949			8.00
9.00	00900	124,890	75,220	2,091	699,838		9.00
10.00	01000	80,548	64,327	1,157	14,906	481,891	10.00
11.00	01100	100,142	166,334	0	38,543	0	11.00
13.00	01300	91,675	37,610	0	8,715	0	13.00
14.00	01400	62,384	94,808	0	21,969	0	14.00
15.00	01500	415,337	59,044	0	13,682	0	15.00
16.00	01600	346,762	176,970	0	41,008	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	709,045	283,255	84,028	65,637	379,206	30.00
31.00	03100	280,158	97,800	24,199	22,662	102,685	31.00
43.00	04300	62,912	17,554	4,003	4,068	0	43.00
44.00	04400	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	524,466	322,618	31,805	74,758	0	50.00
51.00	05100	0	0	0	0	0	51.00
52.00	05200	170,785	241,765	8,185	56,022	0	52.00
53.00	05300	4,423	8,812	0	2,042	0	53.00
54.00	05400	396,882	215,445	12,455	49,923	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	341,932	91,652	4,626	21,238	0	59.00
60.00	06000	564,946	175,591	0	40,688	0	60.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	157,654	52,990	0	12,279	0	65.00
66.00	06600	107,595	101,493	4,938	23,518	0	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	69,424	66,361	2,491	15,377	0	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
75.00	07500	0	0	0	0	0	75.00
75.01	07501	7,094	11,500	0	2,665	0	75.01
76.97	07697	28,586	31,392	0	7,274	0	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	485,649	138,051	41,903	31,990	0	91.00
92.00	09200	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	0	0	0	95.00
101.00	10100	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
118.00		5,799,003	2,608,757	221,881	568,964	481,891	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	1,669	14,609	0	3,385	0	190.00
192.00	19200	49,663	434,768	0	100,747	0	192.00
193.00	19300	0	0	0	0	0	193.00
194.00	07950	109,428	7,667	0	1,777	0	194.00
194.01	07951	13,739	4,722	0	1,094	0	194.01
194.02	07952	62,696	41,210	0	9,549	0	194.02
194.03	07953	56,012	39,153	1,068	9,073	0	194.03
194.04	07954	36,788	22,650	0	5,249	0	194.04
194.05	07955	5,815	0	0	0	0	194.05
194.06	07956	8,028	0	0	0	0	194.06
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		6,142,841	3,173,536	222,949	699,838	481,891	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151335

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

Worksheet B
Part I
Date/Time Prepared:
11/26/2012 3:42 pm

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	704,045					11.00
13.00	01300	11,702	514,991				13.00
14.00	01400	13,699		441,437			14.00
15.00	01500	25,513		13,762	2,182,293		15.00
16.00	01600	89,438				2,035,889	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	156,355	226,869	44,018		96,691	30.00
31.00	03100	44,864	65,099	12,595		46,572	31.00
43.00	04300	11,122	16,138			11,410	43.00
44.00	04400						44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	55,709	80,835	251,741		412,963	50.00
51.00	05100						51.00
52.00	05200	26,143	37,934			25,916	52.00
53.00	05300					12,957	53.00
54.00	05400	52,805		3,781		419,853	54.00
57.00	05700						57.00
58.00	05800						58.00
59.00	05900	17,059		80,272		125,687	59.00
60.00	06000	38,905		4,302		344,630	60.00
64.00	06400						64.00
65.00	06500	25,063		2,127		89,088	65.00
66.00	06600	16,255		1,830		36,549	66.00
67.00	06700						67.00
68.00	06800						68.00
69.00	06900	11,512		2,428		75,381	69.00
70.00	07000						70.00
71.00	07100						71.00
72.00	07200						72.00
73.00	07300				2,182,293	150,308	73.00
75.00	07500						75.00
75.01	07501			2,251		1,564	75.01
76.97	07697	5,654		294		6,572	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	60,727	88,116	18,553		179,748	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500						95.00
101.00	10100						101.00
SPECIAL PURPOSE COST CENTERS							
118.00		662,525	514,991	437,954	2,182,293	2,035,889	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000						190.00
192.00	19200						192.00
193.00	19300						193.00
194.00	07950	1,553					194.00
194.01	07951	3,899					194.01
194.02	07952	13,709		2,303			194.02
194.03	07953	13,257		855			194.03
194.04	07954	9,102		325			194.04
194.05	07955						194.05
194.06	07956						194.06
200.00							200.00
201.00							201.00
202.00		704,045	514,991	441,437	2,182,293	2,035,889	202.00

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	4,870,385	0	4,870,385
31.00	03100	INTENSIVE CARE UNIT	1,812,952	0	1,812,952
43.00	04300	NURSERY	377,887	0	377,887
44.00	04400	SKILLED NURSING FACILITY	0	0	0
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	3,844,685	0	3,844,685
51.00	05100	RECOVERY ROOM	0	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,247,261	0	1,247,261
53.00	05300	ANESTHESIOLOGY	45,858	0	45,858
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,732,560	0	2,732,560
57.00	05700	CT SCAN	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	2,044,929	0	2,044,929
60.00	06000	LABORATORY	3,420,149	0	3,420,149
64.00	06400	INTRAVENOUS THERAPY	0	0	0
65.00	06500	RESPIRATORY THERAPY	967,388	0	967,388
66.00	06600	PHYSICAL THERAPY	720,902	0	720,902
67.00	06700	OCCUPATIONAL THERAPY	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0
69.00	06900	ELECTROCARDIOLOGY	519,601	0	519,601
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	2,332,601	0	2,332,601
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0
75.01	07501	SLEEP DISORDER	53,342	0	53,342
76.97	07697	CARDIAC REHABILITATION	193,674	0	193,674
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	2,979,854	0	2,979,854
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	0
101.00	10100	HOME HEALTH AGENCY	0	0	0
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	28,164,028	0	28,164,028
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	26,313	0	26,313
192.00	19200	PHYSICIANS' PRIVATE OFFICES	783,065	0	783,065
193.00	19300	NONPAID WORKERS	0	0	0
194.00	07950	MARKETING	556,453	0	556,453
194.01	07951	FOUNDATION	78,197	0	78,197
194.02	07952	COMMUNITY OUTREACH	379,286	0	379,286
194.03	07953	WIC	342,603	0	342,603
194.04	07954	GRANTS	220,698	0	220,698
194.05	07955	VACANT SPACE	28,987	0	28,987
194.06	07956	OLD AMBULANCE CENTER	40,017	0	40,017
200.00		Cross Foot Adjustments	0	0	0
201.00		Negative Cost Centers	0	0	0
202.00		TOTAL (sum lines 118-201)	30,619,647	0	30,619,647

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151335

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

Worksheet B
Part II
Date/Time Prepared:
11/26/2012 3:42 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	
		BLDG & FIXT	MVBLE EQUIP			
		0	1:00			
GENERAL SERVICE COST CENTERS						
1.00	00100					1.00
2.00	00200					2.00
4.00	00400					4.00
5.00	00500	4,562	159,913	125,502	289,977	9,675
7.00	00700	12,191	118,072	92,666	222,929	2,048
8.00	00800		19,933	15,644	35,577	45
9.00	00900		19,182	15,054	34,236	1,307
10.00	01000		16,404	12,874	29,278	571
11.00	01100		42,417	33,290	75,707	812
13.00	01300		9,591	7,527	17,118	1,359
14.00	01400	1,467	24,177	18,975	44,619	755
15.00	01500		15,057	11,817	26,874	2,562
16.00	01600	13,578	45,130	35,419	94,127	4,473
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	17,042	72,233	56,690	145,965	10,935
31.00	03100	10,223	24,940	19,574	54,737	4,424
43.00	04300		4,477	3,513	7,990	987
44.00	04400					
ANCILLARY SERVICE COST CENTERS						
50.00	05000	118,827	82,271	64,569	265,667	4,464
51.00	05100					
52.00	05200		61,653	48,387	110,040	2,321
53.00	05300		2,247	1,764	4,011	
54.00	05400	391,267	54,941	43,119	489,327	3,967
57.00	05700					
58.00	05800					
59.00	05900		23,372	18,343	41,715	1,749
60.00	06000	45,660	44,778	35,143	125,581	2,152
64.00	06400					
65.00	06500	9,895	13,513	10,605	34,013	2,439
66.00	06600	1,400	25,882	20,313	47,595	1,555
67.00	06700					
68.00	06800					
69.00	06900		16,923	13,281	30,204	1,036
70.00	07000					
71.00	07100					
72.00	07200					
73.00	07300					
75.00	07500					
75.01	07501		2,933	2,302	5,235	42
76.97	07697		8,005	6,283	14,288	429
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	1,600	35,205	27,629	64,434	4,710
92.00	09200					
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	31,949			31,949	
101.00	10100					
SPECIAL PURPOSE COST CENTERS						
118.00		659,661	980,927	769,854	2,410,442	64,817
NONREIMBURSABLE COST CENTERS						
190.00	19000		3,726	2,924	6,650	
192.00	19200		110,872	87,015	197,887	
193.00	19300					
194.00	07950		1,955	1,534	3,489	57
194.01	07951		1,204	945	2,149	223
194.02	07952		10,509	8,248	18,757	899
194.03	07953	39,765	9,984	7,836	57,585	674
194.04	07954		5,776	4,533	10,309	579
194.05	07955		12,983	10,189	23,172	
194.06	07956					
200.00						
201.00						
202.00		699,426	1,137,936	893,078	2,730,440	67,249

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151335

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

Worksheet B
Part II
Date/Time Prepared:
11/26/2012 3:42 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	299,652				5.00
7.00	00700	OPERATION OF PLANT	31,056	256,033			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,417	6,306	43,345		8.00
9.00	00900	HOUSEKEEPING	6,092	6,069	406	48,110	9.00
10.00	01000	DIETARY	3,929	5,190	225	1,025	40,218
11.00	01100	CAFETERIA	4,885	13,419	0	2,650	0
13.00	01300	NURSING ADMINISTRATION	4,472	3,034	0	599	0
14.00	01400	CENTRAL SERVICES & SUPPLY	3,043	7,649	0	1,510	0
15.00	01500	PHARMACY	20,260	4,764	0	941	0
16.00	01600	MEDICAL RECORDS & LIBRARY	16,915	14,277	0	2,819	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	34,595	22,852	16,337	4,512	31,648
31.00	03100	INTENSIVE CARE UNIT	13,666	7,890	4,705	1,558	8,570
43.00	04300	NURSERY	3,069	1,416	778	280	0
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	25,583	26,028	6,183	5,139	0
51.00	05100	RECOVERY ROOM	0	0	0	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,331	19,505	1,591	3,851	0
53.00	05300	ANESTHESIOLOGY	216	711	0	140	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	19,360	17,382	2,422	3,432	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	16,679	7,394	899	1,460	0
60.00	06000	LABORATORY	27,558	14,166	0	2,797	0
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	7,690	4,275	0	844	0
66.00	06600	PHYSICAL THERAPY	5,248	8,188	960	1,617	0
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	3,386	5,354	484	1,057	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0
75.01	07501	SLEEP DISORDER	346	928	0	183	0
76.97	07697	CARDIAC REHABILITATION	1,394	2,533	0	500	0
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	23,690	11,138	8,147	2,199	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	282,880	210,468	43,137	39,113	40,218
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	81	1,179	0	233	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,423	35,075	0	6,926	0
193.00	19300	NONPAID WORKERS	0	0	0	0	0
194.00	07950	MARKETING	5,338	619	0	122	0
194.01	07951	FOUNDATION	670	381	0	75	0
194.02	07952	COMMUNITY OUTREACH	3,058	3,325	0	656	0
194.03	07953	WIC	2,732	3,159	208	624	0
194.04	07954	GRANTS	1,794	1,827	0	361	0
194.05	07955	VACANT SPACE	284	0	0	0	0
194.06	07956	OLD AMBULANCE CENTER	392	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)	299,652	256,033	43,345	48,110	40,218

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151335

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

Worksheet B
Part II
Date/Time Prepared:
11/26/2012 3:42 pm

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	97,473					11.00
13.00	01300	1,620	28,202				13.00
14.00	01400	1,897	0	59,473			14.00
15.00	01500	3,532	0	1,854	60,787		15.00
16.00	01600	12,382	0	0	0	144,993	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	21,647	12,424	5,930	0	6,885	30.00
31.00	03100	6,211	3,565	1,697	0	3,316	31.00
43.00	04300	1,540	884	0	0	812	43.00
44.00	04400	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	7,713	4,427	33,915	0	29,405	50.00
51.00	05100	0	0	0	0	0	51.00
52.00	05200	3,619	2,077	0	0	1,845	52.00
53.00	05300	0	0	0	0	923	53.00
54.00	05400	7,311	0	509	0	29,924	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	2,362	0	10,815	0	8,950	59.00
60.00	06000	5,386	0	580	0	24,539	60.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	3,470	0	287	0	6,343	65.00
66.00	06600	2,250	0	247	0	2,602	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	1,594	0	327	0	5,368	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	60,787	10,703	73.00
75.00	07500	0	0	0	0	0	75.00
75.01	07501	0	0	303	0	111	75.01
76.97	07697	783	0	40	0	468	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	8,408	4,825	2,500	0	12,799	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	0	0	0	95.00
101.00	10100	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
118.00		91,725	28,202	59,004	60,787	144,993	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
193.00	19300	0	0	0	0	0	193.00
194.00	07950	215	0	0	0	0	194.00
194.01	07951	540	0	0	0	0	194.01
194.02	07952	1,898	0	310	0	0	194.02
194.03	07953	1,835	0	115	0	0	194.03
194.04	07954	1,260	0	44	0	0	194.04
194.05	07955	0	0	0	0	0	194.05
194.06	07956	0	0	0	0	0	194.06
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		97,473	28,202	59,473	60,787	144,993	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151335

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

Worksheet B
Part II
Date/Time Prepared:
11/26/2012 3:42 pm

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	313,730	0	313,730
31.00	03100	INTENSIVE CARE UNIT	110,339	0	110,339
43.00	04300	NURSERY	17,756	0	17,756
44.00	04400	SKILLED NURSING FACILITY	0	0	0
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	408,524	0	408,524
51.00	05100	RECOVERY ROOM	0	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	153,180	0	153,180
53.00	05300	ANESTHESIOLOGY	6,001	0	6,001
54.00	05400	RADIOLOGY-DIAGNOSTIC	573,634	0	573,634
57.00	05700	CT SCAN	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	92,023	0	92,023
60.00	06000	LABORATORY	202,759	0	202,759
64.00	06400	INTRAVENOUS THERAPY	0	0	0
65.00	06500	RESPIRATORY THERAPY	59,361	0	59,361
66.00	06600	PHYSICAL THERAPY	70,262	0	70,262
67.00	06700	OCCUPATIONAL THERAPY	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0
69.00	06900	ELECTROCARDIOLOGY	48,810	0	48,810
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	71,490	0	71,490
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0
75.01	07501	SLEEP DISORDER	7,148	0	7,148
76.97	07697	CARDIAC REHABILITATION	20,435	0	20,435
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	142,850	0	142,850
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	31,949	0	31,949
101.00	10100	HOME HEALTH AGENCY	0	0	0
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,330,251	0	2,330,251
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	8,143	0	8,143
192.00	19200	PHYSICIANS' PRIVATE OFFICES	242,311	0	242,311
193.00	19300	NONPAID WORKERS	0	0	0
194.00	07950	MARKETING	9,840	0	9,840
194.01	07951	FOUNDATION	4,038	0	4,038
194.02	07952	COMMUNITY OUTREACH	28,903	0	28,903
194.03	07953	WIC	66,932	0	66,932
194.04	07954	GRANTS	16,174	0	16,174
194.05	07955	VACANT SPACE	23,456	0	23,456
194.06	07956	OLD AMBULANCE CENTER	392	0	392
200.00		Cross Foot Adjustments	0	0	0
201.00		Negative Cost Centers	0	0	0
202.00		TOTAL (sum lines 118-201)	2,730,440	0	2,730,440

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQURE FEET)	MVBLE EQUIP (SQURE FEET)				
	1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	190,902				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		190,902			2.00
4.00 00400	EMPLOYEE BENEFITS	6,321	6,321	11,853,529		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	26,827	26,827	1,705,470	-6,142,841	24,476,806
7.00 00700	OPERATION OF PLANT	19,808	19,808	361,074	0	2,536,868
8.00 00800	LAUNDRY & LINEN SERVICE	3,344	3,344	7,847	0	115,738
9.00 00900	HOUSEKEEPING	3,218	3,218	230,473	0	497,637
10.00 01000	DIETARY	2,752	2,752	100,688	0	320,953
11.00 01100	CAFETERIA	7,116	7,116	143,059	0	399,026
13.00 01300	NURSING ADMINISTRATION	1,609	1,609	239,550	0	365,289
14.00 01400	CENTRAL SERVICES & SUPPLY	4,056	4,056	133,116	0	248,577
15.00 01500	PHARMACY	2,526	2,526	451,662	0	1,654,955
16.00 01600	MEDICAL RECORDS & LIBRARY	7,571	7,571	788,442	0	1,381,711
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	12,118	12,118	1,926,880	0	2,825,281
31.00 03100	INTENSIVE CARE UNIT	4,184	4,184	779,762	0	1,116,318
43.00 04300	NURSERY	751	751	174,045	0	250,680
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	13,802	13,802	786,951	0	2,089,790
51.00 05100	RECOVERY ROOM	0	0	0	0	0
52.00 05200	DELIVERY ROOM & LABOR ROOM	10,343	10,343	409,113	0	680,511
53.00 05300	ANESTHESIOLOGY	377	377	0	0	17,624
54.00 05400	RADIOLOGY-DIAGNOSTIC	9,217	9,217	699,335	0	1,581,416
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	3,921	3,921	308,331	0	1,362,463
60.00 06000	LABORATORY	7,512	7,512	379,323	0	2,251,087
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00 06500	RESPIRATORY THERAPY	2,267	2,267	429,937	0	628,187
66.00 06600	PHYSICAL THERAPY	4,342	4,342	274,060	0	428,724
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00 06900	ELECTROCARDIOLOGY	2,839	2,839	182,595	0	276,627
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
75.00 07500	ASC (NON-DISTINCT PART)	0	0	0	0	0
75.01 07501	SLEEP DISORDER	492	492	7,404	0	28,268
76.97 07697	CARDIAC REHABILITATION	1,343	1,343	75,562	0	113,902
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	5,906	5,906	830,216	0	1,935,117
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	0	0	0	0	0
101.00 10100	HOME HEALTH AGENCY	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	164,562	164,562	11,424,895	-6,142,841	23,106,749
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	625	625	0	0	6,650
192.00 19200	PHYSICIANS' PRIVATE OFFICES	18,600	18,600	0	0	197,887
193.00 19300	NONPAID WORKERS	0	0	0	0	0
194.00 07950	MARKETING	328	328	10,095	0	436,028
194.01 07951	FOUNDATION	202	202	39,332	0	54,743
194.02 07952	COMMUNITY OUTREACH	1,763	1,763	158,382	0	249,819
194.03 07953	WIC	1,675	1,675	118,843	0	223,185
194.04 07954	GRANTS	969	969	101,982	0	146,584
194.05 07955	VACANT SPACE	2,178	2,178	0	0	23,172
194.06 07956	OLD AMBULANCE CENTER	0	0	0	0	31,989
200.00	Cross Foot Adjustments					
201.00	Negative Cost Centers					
202.00	Cost to be allocated (per Wkst. B, Part I)	1,137,936	893,078	3,659,383		6,142,841
203.00	Unit cost multiplier (Wkst. B, Part I)	5.960839	4.678201	0.308717		0.250966
204.00	Cost to be allocated (per Wkst. B, Part II)			67,249		299,652
205.00	Unit cost multiplier (Wkst. B, Part II)			0.005673		0.012242

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Cost Center Description		OPERATION OF PLANT (SQ. FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQ. FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (PAID HOURS)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	135,768				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,344	5,012			8.00
9.00	00900	HOUSEKEEPING	3,218	47	129,206		9.00
10.00	01000	DIETARY	2,752	26	2,752	4,172	10.00
11.00	01100	CAFETERIA	7,116	0	7,116	0	366,332
13.00	01300	NURSING ADMINISTRATION	1,609	0	1,609	0	6,089
14.00	01400	CENTRAL SERVICES & SUPPLY	4,056	0	4,056	0	7,128
15.00	01500	PHARMACY	2,526	0	2,526	0	13,275
16.00	01600	MEDICAL RECORDS & LIBRARY	7,571	0	7,571	0	46,537
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	12,118	1,889	12,118	3,283	81,354
31.00	03100	INTENSIVE CARE UNIT	4,184	544	4,184	889	23,344
43.00	04300	NURSERY	751	90	751	0	5,787
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	13,802	715	13,802	0	28,987
51.00	05100	RECOVERY ROOM	0	0	0	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	10,343	184	10,343	0	13,603
53.00	05300	ANESTHESIOLOGY	377	0	377	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,217	280	9,217	0	27,476
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	3,921	104	3,921	0	8,876
60.00	06000	LABORATORY	7,512	0	7,512	0	20,243
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	2,267	0	2,267	0	13,041
66.00	06600	PHYSICAL THERAPY	4,342	111	4,342	0	8,458
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	2,839	56	2,839	0	5,990
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0
75.01	07501	SLEEP DISORDER	492	0	492	0	0
76.97	07697	CARDIAC REHABILITATION	1,343	0	1,343	0	2,942
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	5,906	942	5,906	0	31,598
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	111,606	4,988	105,044	4,172	344,728
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	625	0	625	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	18,600	0	18,600	0	0
193.00	19300	NONPAID WORKERS	0	0	0	0	0
194.00	07950	MARKETING	328	0	328	0	808
194.01	07951	FOUNDATION	202	0	202	0	2,029
194.02	07952	COMMUNITY OUTREACH	1,763	0	1,763	0	7,133
194.03	07953	WIC	1,675	24	1,675	0	6,898
194.04	07954	GRANTS	969	0	969	0	4,736
194.05	07955	VACANT SPACE	0	0	0	0	0
194.06	07956	OLD AMBULANCE CENTER	0	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers					
202.00		Cost to be allocated (per Wkst. B, Part I)	3,173,536	222,949	699,838	481,891	704,045
203.00		Unit cost multiplier (Wkst. B, Part I)	23.374698	44.483041	5.416451	115.505992	1.921877
204.00		Cost to be allocated (per Wkst. B, Part II)	256,033	43,345	48,110	40,218	97,473
205.00		Unit cost multiplier (Wkst. B, Part II)	1.885813	8.648244	0.372351	9.639981	0.266078

Cost Center Description		NURSING ADMINISTRATION (PAID HOURS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS						
1.00	00100					1.00
2.00	00200					2.00
4.00	00400					4.00
5.00	00500					5.00
7.00	00700					7.00
8.00	00800					8.00
9.00	00900					9.00
10.00	01000					10.00
11.00	01100					11.00
13.00	01300	184,673				13.00
14.00	01400	0	761,548			14.00
15.00	01500	0	23,741	100		15.00
16.00	01600	0	0	0	61,845,145	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	81,354	75,938	0	2,937,233	30.00
31.00	03100	23,344	21,729	0	1,414,744	31.00
43.00	04300	5,787	0	0	346,596	43.00
44.00	04400	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	28,987	434,294	0	12,544,836	50.00
51.00	05100	0	0	0	0	51.00
52.00	05200	13,603	0	0	787,275	52.00
53.00	05300	0	0	0	393,598	53.00
54.00	05400	0	6,523	0	12,753,920	54.00
57.00	05700	0	0	0	0	57.00
58.00	05800	0	0	0	0	58.00
59.00	05900	0	138,482	0	3,818,054	59.00
60.00	06000	0	7,421	0	10,469,017	60.00
64.00	06400	0	0	0	0	64.00
65.00	06500	0	3,669	0	2,706,269	65.00
66.00	06600	0	3,157	0	1,110,279	66.00
67.00	06700	0	0	0	0	67.00
68.00	06800	0	0	0	0	68.00
69.00	06900	0	4,188	0	2,289,890	69.00
70.00	07000	0	0	0	0	70.00
71.00	07100	0	0	0	0	71.00
72.00	07200	0	0	0	0	72.00
73.00	07300	0	0	100	4,565,992	73.00
75.00	07500	0	0	0	0	75.00
75.01	07501	0	3,884	0	47,498	75.01
76.97	07697	0	507	0	199,641	76.97
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	31,598	32,007	0	5,460,303	91.00
92.00	09200					92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	0	0	0	0	95.00
101.00	10100	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
118.00		184,673	755,540	100	61,845,145	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	0	0	0	0	190.00
192.00	19200	0	0	0	0	192.00
193.00	19300	0	0	0	0	193.00
194.00	07950	0	0	0	0	194.00
194.01	07951	0	0	0	0	194.01
194.02	07952	0	3,973	0	0	194.02
194.03	07953	0	1,475	0	0	194.03
194.04	07954	0	560	0	0	194.04
194.05	07955	0	0	0	0	194.05
194.06	07956	0	0	0	0	194.06
200.00						200.00
201.00						201.00
202.00		514,991	441,437	2,182,293	2,035,889	202.00
203.00		2.788664	0.579657	21,822.930000	0.032919	203.00
204.00		28,202	59,473	60,787	144,993	204.00
205.00		0.152713	0.078095	607.870000	0.002344	205.00

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COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151335

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

Worksheet C
Part I
Date/Time Prepared:
11/26/2012 3:42 pm

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Title XVIII		Hospital		Cost	
				Total Costs	RCE Disallowance	Total Costs	Total Costs		
								3.00	4.00
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	4,870,385		4,870,385	0		0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,812,952		1,812,952	0		0	31.00
43.00	04300	NURSERY	377,887		377,887	0		0	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0		0	44.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	3,844,685		3,844,685	0		0	50.00
51.00	05100	RECOVERY ROOM	0		0	0		0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,247,261		1,247,261	0		0	52.00
53.00	05300	ANESTHESIOLOGY	45,858		45,858	0		0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,732,560		2,732,560	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	2,044,929		2,044,929	0		0	59.00
60.00	06000	LABORATORY	3,420,149		3,420,149	0		0	60.00
64.00	06400	INTRAVENOUS THERAPY	0		0	0		0	64.00
65.00	06500	RESPIRATORY THERAPY	967,388	0	967,388	0		0	65.00
66.00	06600	PHYSICAL THERAPY	720,902	0	720,902	0		0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0		0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0		0	68.00
69.00	06900	ELECTROCARDIOLOGY	519,601		519,601	0		0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0		0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0		0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0		0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,332,601		2,332,601	0		0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0		0	0		0	75.00
75.01	07501	SLEEP DISORDER	53,342		53,342	0		0	75.01
76.97	07697	CARDIAC REHABILITATION	193,674		193,674	0		0	76.97
OUTPATIENT SERVICE COST CENTERS									
91.00	09100	EMERGENCY	2,979,854		2,979,854	0		0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,004,761		1,004,761	0		0	92.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	0		0	0		0	95.00
101.00	10100	HOME HEALTH AGENCY	0		0	0		0	101.00
200.00		Subtotal (see instructions)	29,168,789	0	29,168,789	0		0	200.00
201.00		Less Observation Beds	1,004,761		1,004,761	0		0	201.00
202.00		Total (see instructions)	28,164,028	0	28,164,028	0		0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151335

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

Worksheet C
Part I
Date/Time Prepared:
11/26/2012 3:42 pm

Cost Center Description		Title XVIII			Hospital	Cost
		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
		Inpatient	Outpatient	Total (col. 6 + col. 7)		
		6.00	7.00	8.00	9.00	10.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,152,085		2,152,085	30.00
31.00	03100	INTENSIVE CARE UNIT	1,414,744		1,414,744	31.00
43.00	04300	NURSERY	346,596		346,596	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,205,569	9,339,267	12,544,836	50.00
51.00	05100	RECOVERY ROOM	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	786,485	790	787,275	52.00
53.00	05300	ANESTHESIOLOGY	74,572	319,026	393,598	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,046,785	11,707,135	12,753,920	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	1,494,909	2,323,145	3,818,054	59.00
60.00	06000	LABORATORY	1,522,133	8,946,884	10,469,017	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,528,112	1,178,157	2,706,269	65.00
66.00	06600	PHYSICAL THERAPY	106,188	1,004,091	1,110,279	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	707,344	1,582,546	2,289,890	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,479,600	2,086,392	4,565,992	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	75.00
75.01	07501	SLEEP DISORDER	0	47,498	47,498	75.01
76.97	07697	CARDIAC REHABILITATION	0	199,641	199,641	76.97
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	261,364	5,198,939	5,460,303	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	785,148	785,148	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	101.00
200.00		Subtotal (see instructions)	17,126,486	44,718,659	61,845,145	200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)	17,126,486	44,718,659	61,845,145	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151335

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

Worksheet C
Part I
Date/Time Prepared:
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Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000				30.00
31.00	03100				31.00
43.00	04300				43.00
44.00	04400				44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	0.000000			50.00
51.00	05100	0.000000			51.00
52.00	05200	0.000000			52.00
53.00	05300	0.000000			53.00
54.00	05400	0.000000			54.00
57.00	05700	0.000000			57.00
58.00	05800	0.000000			58.00
59.00	05900	0.000000			59.00
60.00	06000	0.000000			60.00
64.00	06400	0.000000			64.00
65.00	06500	0.000000			65.00
66.00	06600	0.000000			66.00
67.00	06700	0.000000			67.00
68.00	06800	0.000000			68.00
69.00	06900	0.000000			69.00
70.00	07000	0.000000			70.00
71.00	07100	0.000000			71.00
72.00	07200	0.000000			72.00
73.00	07300	0.000000			73.00
75.00	07500	0.000000			75.00
75.01	07501	0.000000			75.01
76.97	07697	0.000000			76.97
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	0.000000			91.00
92.00	09200	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	0.000000			95.00
101.00	10100				101.00
200.00					200.00
201.00					201.00
202.00					202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151335

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

Worksheet C
Part I
Date/Time Prepared:
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Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Title XIX		Hospital		Cost
				Total Costs	RCE Disallowance	Total Costs		
								3.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,870,385		4,870,385	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,812,952		1,812,952	0	0	31.00
43.00	04300	NURSERY	377,887		377,887	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,844,685		3,844,685	0	0	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,247,261		1,247,261	0	0	52.00
53.00	05300	ANESTHESIOLOGY	45,858		45,858	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,732,560		2,732,560	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	2,044,929		2,044,929	0	0	59.00
60.00	06000	LABORATORY	3,420,149		3,420,149	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	967,388	0	967,388	0	0	65.00
66.00	06600	PHYSICAL THERAPY	720,902	0	720,902	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	519,601		519,601	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,332,601		2,332,601	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0		0	0	0	75.00
75.01	07501	SLEEP DISORDER	53,342		53,342	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	193,674		193,674	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	2,979,854		2,979,854	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,004,761		1,004,761	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0		0	0	0	101.00
200.00		Subtotal (see instructions)	29,168,789	0	29,168,789	0	0	200.00
201.00		Less Observation Beds	1,004,761		1,004,761	0	0	201.00
202.00		Total (see instructions)	28,164,028	0	28,164,028	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151335

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

Worksheet C
Part I
Date/Time Prepared:
11/26/2012 3:42 pm

Cost Center Description		Title XIX			Hospital	Cost
		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
		Inpatient	Outpatient	Total (col. 6 + col. 7)		
6.00	7.00	8.00	9.00	10.00		
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,152,085		2,152,085	30.00
31.00	03100	INTENSIVE CARE UNIT	1,414,744		1,414,744	31.00
43.00	04300	NURSERY	346,596		346,596	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,205,569	9,339,267	12,544,836	50.00
51.00	05100	RECOVERY ROOM	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	786,485	790	787,275	52.00
53.00	05300	ANESTHESIOLOGY	74,572	319,026	393,598	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,046,785	11,707,135	12,753,920	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	1,494,909	2,323,145	3,818,054	59.00
60.00	06000	LABORATORY	1,522,133	8,946,884	10,469,017	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,528,112	1,178,157	2,706,269	65.00
66.00	06600	PHYSICAL THERAPY	106,188	1,004,091	1,110,279	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	707,344	1,582,546	2,289,890	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,479,600	2,086,392	4,565,992	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	75.00
75.01	07501	SLEEP DISORDER	0	47,498	47,498	75.01
76.97	07697	CARDIAC REHABILITATION	0	199,641	199,641	76.97
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	261,364	5,198,939	5,460,303	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	785,148	785,148	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	101.00
200.00		Subtotal (see instructions)	17,126,486	44,718,659	61,845,145	200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)	17,126,486	44,718,659	61,845,145	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151335

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

Worksheet C
Part I
Date/Time Prepared:
11/26/2012 3:42 pm

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000				30.00
31.00	03100				31.00
43.00	04300				43.00
44.00	04400				44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	0.000000			50.00
51.00	05100	0.000000			51.00
52.00	05200	0.000000			52.00
53.00	05300	0.000000			53.00
54.00	05400	0.000000			54.00
57.00	05700	0.000000			57.00
58.00	05800	0.000000			58.00
59.00	05900	0.000000			59.00
60.00	06000	0.000000			60.00
64.00	06400	0.000000			64.00
65.00	06500	0.000000			65.00
66.00	06600	0.000000			66.00
67.00	06700	0.000000			67.00
68.00	06800	0.000000			68.00
69.00	06900	0.000000			69.00
70.00	07000	0.000000			70.00
71.00	07100	0.000000			71.00
72.00	07200	0.000000			72.00
73.00	07300	0.000000			73.00
75.00	07500	0.000000			75.00
75.01	07501	0.000000			75.01
76.97	07697	0.000000			76.97
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	0.000000			91.00
92.00	09200	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	0.000000			95.00
101.00	10100				101.00
200.00					200.00
201.00					201.00
202.00					202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 151335

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

Worksheet D
Part II
Date/Time Prepared:
11/26/2012 3:42 pm

Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Title XVIII		Hospital Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)			
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	408,524	12,544,836	0.032565	1,493,447	48,634	50.00
51.00 05100 RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	153,180	787,275	0.194570	0	0	52.00
53.00 05300 ANESTHESIOLOGY	6,001	393,598	0.015247	29,538	450	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	573,634	12,753,920	0.044977	803,845	36,155	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	92,023	3,818,054	0.024102	637,106	15,356	59.00
60.00 06000 LABORATORY	202,759	10,469,017	0.019368	958,517	18,565	60.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	59,361	2,706,269	0.021935	308,421	6,765	65.00
66.00 06600 PHYSICAL THERAPY	70,262	1,110,279	0.063283	84,452	5,344	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	48,810	2,289,890	0.021315	674,509	14,377	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	71,490	4,565,992	0.015657	1,525,398	23,883	73.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
75.01 07501 SLEEP DISORDER	7,148	47,498	0.150491	0	0	75.01
76.97 07697 CARDIAC REHABILITATION	20,435	199,641	0.102359	0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
91.00 09100 EMERGENCY	142,850	5,460,303	0.026162	8,016	210	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	785,148	0.000000	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50-199)	1,856,477	57,931,720		6,523,249	169,739	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151335

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

Worksheet D
Part IV
Date/Time Prepared:
11/26/2012 3:42 pm

Cost Center Description	Title XVIII			Hospital	Cost	
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
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
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0	0	75.00
75.01	07501 SLEEP DISORDER	0	0	0	0	75.01
76.97	07697 CARDIAC REHABILITATION	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES					95.00
200.00	Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151335

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

Worksheet D
Part IV
Date/Time Prepared:
11/26/2012 3:42 pm

Cost Center Description		Title XVIII			Hospital			
		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	12,544,836	0.000000	0.000000	1,493,447	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	787,275	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	393,598	0.000000	0.000000	29,538	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	12,753,920	0.000000	0.000000	803,845	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	3,818,054	0.000000	0.000000	637,106	59.00
60.00	06000	LABORATORY	0	10,469,017	0.000000	0.000000	958,517	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	2,706,269	0.000000	0.000000	308,421	65.00
66.00	06600	PHYSICAL THERAPY	0	1,110,279	0.000000	0.000000	84,452	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,289,890	0.000000	0.000000	674,509	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,565,992	0.000000	0.000000	1,525,398	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0.000000	0	75.00
75.01	07501	SLEEP DISORDER	0	47,498	0.000000	0.000000	0	75.01
76.97	07697	CARDIAC REHABILITATION	0	199,641	0.000000	0.000000	0	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	5,460,303	0.000000	0.000000	8,016	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	785,148	0.000000	0.000000	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	57,931,720			6,523,249	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151335

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

Worksheet D
Part IV
Date/Time Prepared:
11/26/2012 3:42 pm

Cost Center Description	Title XVIII			Hospital Cost	
	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School
	11.00	12.00	13.00	21.00	22.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0	0	0	0	0
51.00 05100 RECOVERY ROOM	0	0	0	0	0
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	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	0	0	0	0	0
60.00 06000 LABORATORY	0	0	0	0	0
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0	0	0
75.01 07501 SLEEP DISORDER	0	0	0	0	0
76.97 07697 CARDIAC REHABILITATION	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS					
91.00 09100 EMERGENCY	0	0	0	0	0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS					
95.00 09500 AMBULANCE SERVICES					
200.00 Total (lines 50-199)	0	0	0	0	0

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151335

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

Worksheet D
Part IV
Date/Time Prepared:
11/26/2012 3:42 pm

Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	Title XVIII	Hospital	Cost
		23.00	24.00			
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		75.00
75.01	07501	SLEEP DISORDER	0	0		75.01
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (lines 50-199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151335

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

Worksheet D
Part V
Date/Time Prepared:
11/26/2012 3:42 pm

Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Hospital	Cost	
			PPS Reimbursed Services (see instructions)	Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)			Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)
		1.00	2.00	3.00	4.00		
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.306476	0	2,986,708	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.584276	0	790	0	52.00
53.00	05300	ANESTHESIOLOGY	0.116510	0	121,795	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.214253	0	4,272,535	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	0.535595	0	1,033,590	0	59.00
60.00	06000	LABORATORY	0.326692	0	2,985,775	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.357462	0	56,116	0	65.00
66.00	06600	PHYSICAL THERAPY	0.649298	0	297,414	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.226911	0	914,124	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.510864	0	800,646	3,481	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	75.00
75.01	07501	SLEEP DISORDER	1.123037	0	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	0.970111	0	107,263	0	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0.545731	0	1,742,379	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.279709	0	458,105	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0.000000	0	0	0	95.00
200.00		Subtotal (see instructions)		0	15,777,240	3,481	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00		Net charges (line 200 +/- line 201)		0	15,777,240	3,481	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151335

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

Worksheet D
Part V
Date/Time Prepared:
11/26/2012 3:42 pm

		Title XVIII			Hospital	Cost
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			
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	915,354	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,252	0	52.00
53.00	05300	ANESTHESIOLOGY	0	14,190	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	915,403	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	553,586	0	59.00
60.00	06000	LABORATORY	0	975,429	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	20,059	0	65.00
66.00	06600	PHYSICAL THERAPY	0	193,110	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	207,425	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	409,021	1,778	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	75.00
75.01	07501	SLEEP DISORDER	0	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	0	104,057	0	76.97
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	950,870	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	586,241	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES		0		95.00
200.00		Subtotal (see instructions)	0	5,845,997	1,778	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges		0		201.00
202.00		Net Charges (line 200 +/- line 201)	0	5,845,997	1,778	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 151335

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

Worksheet D
Part I
Date/Time Prepared:
11/26/2012 3:42 pm

Cost Center Description		Title XIX			Hospital	Cost		
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)		
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	313,730	378	313,352	4,062	77.14	30.00
31.00	03100	INTENSIVE CARE UNIT	110,339		110,339	889	124.12	31.00
43.00	04300	NURSERY	17,756		17,756	517	34.34	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
200.00		Total (lines 30-199)	441,825		441,447	5,468		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 151335

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

Worksheet D
Part I
Date/Time Prepared:
11/26/2012 3:42 pm

Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	Title XIX	Hospital	Cost
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00			
30.00	03000 ADULTS & PEDIATRICS	92	7,097			30.00
31.00	03100 INTENSIVE CARE UNIT	18	2,234			31.00
43.00	04300 NURSERY	14	481			43.00
44.00	04400 SKILLED NURSING FACILITY	0	0			44.00
200.00	Total (lines 30-199)	124	9,812			200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 151335

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

Worksheet D
Part II
Date/Time Prepared:
11/26/2012 3:42 pm

Cost Center Description	Title XIX			Hospital	Cost			
	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)			
	1.00	2.00	3.00	4.00	5.00			
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	408,524	12,544,836	0.032565	789,988	25,726	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	153,180	787,275	0.194570	208,633	40,594	52.00
53.00	05300	ANESTHESIOLOGY	6,001	393,598	0.015247	18,684	285	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	573,634	12,753,920	0.044977	88,709	3,990	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	92,023	3,818,054	0.024102	84,721	2,042	59.00
60.00	06000	LABORATORY	202,759	10,469,017	0.019368	253,553	4,911	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	59,361	2,706,269	0.021935	142,713	3,130	65.00
66.00	06600	PHYSICAL THERAPY	70,262	1,110,279	0.063283	2,779	176	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	48,810	2,289,890	0.021315	32,835	700	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	71,490	4,565,992	0.015657	345,242	5,405	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
75.01	07501	SLEEP DISORDER	7,148	47,498	0.150491	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	20,435	199,641	0.102359	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	142,850	5,460,303	0.026162	62,610	1,638	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	785,148	0.000000	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	1,856,477	57,931,720		2,030,467	88,597	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151335

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

Worksheet D
Part III
Date/Time Prepared:
11/26/2012 3:42 pm

Cost Center Description	Title XIX				Hospital	Cost
	Nursing School	Allied Health Cost	All other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00 04300 NURSERY	0	0	0	0	0	43.00
44.00 04400 SKILLED NURSING FACILITY	0	0	0	0	0	44.00
200.00 Total (lines 30-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS Provider CCN: 151335 Period: From 07/01/2011 To 06/30/2012 Worksheet D Part III Date/Time Prepared: 11/26/2012 3:42 pm

Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Hospital		PSA Adj. Nursing School	
				Inpatient Program Pass-Through Cost (col. 7 x col. 8)	Cost		
	6.00	7.00	8.00	9.00	11.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	4,062	0.00	92	0	30.00
31.00	03100	INTENSIVE CARE UNIT	889	0.00	18	0	31.00
43.00	04300	NURSERY	517	0.00	14	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0.00	0	0	44.00
200.00		Total (lines 30-199)	5,468		124	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151335	Period: From 07/01/2011 To 06/30/2012	Worksheet D Part III Date/Time Prepared: 11/26/2012 3:42 pm
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Cost Center Description	Title XIX		Hospital	Cost	
	PSA Adj. Allied Health Cost	PSA Adj. All Other Medical Education Cost			
	12.00	13.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	31.00
43.00	04300	NURSERY	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	44.00
200.00		Total (lines 30-199)	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151335

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

Worksheet D
Part IV
Date/Time Prepared:
11/26/2012 3:42 pm

Cost Center Description	Title XIX				Hospital	Total Cost (sum of col 1 through col. 4)		
	Non-Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Cost			
	1.00	2.00	3.00	4.00	5.00			
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
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
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75.01	07501	SLEEP DISORDER	0	0	0	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151335

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

Worksheet D
Part IV
Date/Time Prepared:
11/26/2012 3:42 pm

Cost Center Description		Title XIX Hospital				Cost		
		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)		Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	12,544,836	0.000000	0.000000	789,988	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	787,275	0.000000	0.000000	208,633	52.00
53.00	05300	ANESTHESIOLOGY	0	393,598	0.000000	0.000000	18,684	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	12,753,920	0.000000	0.000000	88,709	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	3,818,054	0.000000	0.000000	84,721	59.00
60.00	06000	LABORATORY	0	10,469,017	0.000000	0.000000	253,553	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	2,706,269	0.000000	0.000000	142,713	65.00
66.00	06600	PHYSICAL THERAPY	0	1,110,279	0.000000	0.000000	2,779	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,289,890	0.000000	0.000000	32,835	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,565,992	0.000000	0.000000	345,242	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0.000000	0	75.00
75.01	07501	SLEEP DISORDER	0	47,498	0.000000	0.000000	0	75.01
76.97	07697	CARDIAC REHABILITATION	0	199,641	0.000000	0.000000	0	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	5,460,303	0.000000	0.000000	62,610	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	785,148	0.000000	0.000000	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	57,931,720			2,030,467	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151335

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

Worksheet D
Part IV
Date/Time Prepared:
11/26/2012 3:42 pm

Cost Center Description	Title XIX			Hospital	Cost		
	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School		
	11.00	12.00	13.00	21.00	22.00		
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
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
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
75.01	07501	SLEEP DISORDER	0	0	0	0	75.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151335

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

Worksheet D
Part IV
Date/Time Prepared:
11/26/2012 3:42 pm

Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	Title XIX	Hospital	Cost
		23.00	24.00			
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		75.00
75.01	07501	SLEEP DISORDER	0	0		75.01
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (lines 50-199)	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151335

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

Worksheet D-1

Date/Time Prepared:
11/26/2012 3:42 pm

Cost Center Description		Title XVIII	Hospital	Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			4,102 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			4,062 2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.			0 3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			3,223 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			20 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)			20 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			1,974 9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			0 10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0 14.00
15.00	Total nursery days (title V or XIX only)			0 15.00
16.00	Nursery days (title V or XIX only)			0 16.00
SWING-BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			146.75 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			146.75 20.00
21.00	Total general inpatient routine service cost (see instructions)			4,870,385 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)			2,935 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)			2,935 25.00
26.00	Total swing-bed cost (see instructions)			5,870 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			4,864,515 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)			4,023,175 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			4,023,175 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			1.209123 31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00 32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			1,248.27 33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00 34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00 35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0 36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			4,864,515 37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			1,197.57 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			2,364,003 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)			2,364,003 41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151335

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

Worksheet D-1

Date/Time Prepared:
11/26/2012 3:42 pm

Cost Center Description	Title XVIII				Hospital		Cost
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	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	1,812,952	889	2,039.32	605	1,233,789	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)					2,389,528	48.00	
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					5,987,320	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)					839	87.00	
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,197.57	88.00	
89.00 Observation bed cost (line 87 x line 88) (see instructions)					1,004,761	89.00	

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151335

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

Worksheet D-1

Date/Time Prepared:
11/26/2012 3:42 pm

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

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151335

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

Worksheet D-1

Date/Time Prepared:
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Cost Center Description		Title XIX	Hospital	Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			4,102 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			4,062 2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.			0 3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			3,223 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			20 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)			20 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			92 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)			517 15.00
16.00	Nursery days (title V or XIX only)			14 16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			146.75 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			146.75 20.00
21.00	Total general inpatient routine service cost (see instructions)			4,870,385 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)			2,935 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)			2,935 25.00
26.00	Total swing-bed cost (see instructions)			5,870 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			4,864,515 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)			4,023,175 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			4,023,175 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			1.209123 31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00 32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			1,248.27 33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00 34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00 35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0 36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			4,864,515 37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			1,197.57 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			110,176 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)			110,176 41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151335

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

Worksheet D-1

Date/Time Prepared:
11/26/2012 3:42 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)	377,887	517	730.92	14	10,233		42.00	
Intensive Care Type Inpatient Hospital Units								
43.00 INTENSIVE CARE UNIT	1,812,952	889	2,039.32	18	36,708		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)					992,846		48.00	
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,149,963		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							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)						839	87.00	
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						1,197.57	88.00	
89.00 Observation bed cost (line 87 x line 88) (see instructions)						1,004,761	89.00	

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151335

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

Worksheet D-1
Date/Time Prepared:
11/26/2012 3:42 pm

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 151335

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

Worksheet D-3

Date/Time Prepared:
11/26/2012 3:42 pm

Cost Center Description		Title XVIII	Hospital	Cost	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		1,081,143	30.00
31.00	03100	INTENSIVE CARE UNIT		651,260	31.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.306476	1,493,447	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.584276	0	52.00
53.00	05300	ANESTHESIOLOGY	0.116510	29,538	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.214253	803,845	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	0.535595	637,106	59.00
60.00	06000	LABORATORY	0.326692	958,517	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.357462	308,421	65.00
66.00	06600	PHYSICAL THERAPY	0.649298	84,452	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.226911	674,509	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.510864	1,525,398	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	75.00
75.01	07501	SLEEP DISORDER	1.123037	0	75.01
76.97	07697	CARDIAC REHABILITATION	0.970111	0	76.97
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.545731	8,016	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.279709	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50-94 and 96-98)		6,523,249	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)		6,523,249	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 151335

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

Worksheet D-3

Date/Time Prepared:
11/26/2012 3:42 pm

Cost Center Description		Title XIX	Hospital	Cost
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT	505,438	31.00
43.00	04300	NURSERY	174,306	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.306476 789,988	242,112 50.00
51.00	05100	RECOVERY ROOM	0.000000 0	0 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.584276 208,633	330,532 52.00
53.00	05300	ANESTHESIOLOGY	0.116510 18,684	2,177 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.214253 88,709	19,006 54.00
57.00	05700	CT SCAN	0.000000 0	0 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000 0	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	0.535595 84,721	45,376 59.00
60.00	06000	LABORATORY	0.326692 253,553	82,834 60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000 0	0 64.00
65.00	06500	RESPIRATORY THERAPY	0.357462 142,713	51,014 65.00
66.00	06600	PHYSICAL THERAPY	0.649298 2,779	1,804 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000 0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0.000000 0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	0.226911 32,835	7,451 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000 0	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000 0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000 0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.510864 345,242	176,372 73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000 0	0 75.00
75.01	07501	SLEEP DISORDER	1.123037 0	0 75.01
76.97	07697	CARDIAC REHABILITATION	0.970111 0	0 76.97
OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.545731 62,610	34,168 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.279709 0	0 92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES		95.00
200.00		Total (sum of lines 50-94 and 96-98)	2,030,467	992,846 200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)	0	0 201.00
202.00		Net Charges (line 200 minus line 201)	2,030,467	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151335	Period: From 07/01/2011 To 06/30/2012	Worksheet E Part B Date/Time Prepared: 11/26/2012 3:42 pm
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		Title XVIII	Hospital	Cost	
				1.00	
PART B - MEDICAL AND OTHER HEALTH SERVICES					
1.00	Medical and other services (see instructions)			5,847,775	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)			5,847,775	11.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable charges					
12.00	Ancillary service charges			0	12.00
13.00	Organ acquisition charges (from worksheet D-4, Part III, line 69, col. 4)			0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0	14.00
Customary charges					
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR 413.13(e)			0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	17.00
18.00	Total customary charges (see instructions)			0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)			5,906,253	21.00
22.00	Interns and residents (see instructions)			0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)			0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)			0	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
25.00	Deductibles and coinsurance (for CAH, see instructions)			26,433	25.00
26.00	Deductibles and coinsurance relating to amount on line 24 (for CAH, see instructions)			2,602,930	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)			3,276,890	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)			3,276,890	30.00
31.00	Primary payer payments			1,272	31.00
32.00	Subtotal (line 30 minus line 31)			3,275,618	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)					
33.00	Composite rate ESRD (from worksheet I-5, line 11)			0	33.00
34.00	Allowable bad debts (see instructions)			273,150	34.00
35.00	Adjusted reimbursable bad debts (see instructions)			273,150	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			229,601	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)			3,548,768	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)			3,548,768	40.00
41.00	Interim payments			3,949,421	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)			-400,653	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			0	44.00
TO BE COMPLETED BY CONTRACTOR					
90.00	Original outlier amount (see instructions)			0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0	91.00
92.00	The rate used to calculate the Time Value of Money			0.00	92.00
93.00	Time Value of Money (see instructions)			0	93.00
94.00	Total (sum of lines 91 and 93)			0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 151335

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

Worksheet E
Part B
Date/Time Prepared:
11/26/2012 3:42 pm

Title XVIII		Hospital	Cost
			Overrides
			1.00
WORKSHEET OVERRIDE VALUES			
112.00	Override of Ancillary service charges (line 12)		0 112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151335

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

Worksheet E-1
Part I
Date/Time Prepared:
11/26/2012 3:42 pm

		Title XVIII		Hospital		Cost	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		4,801,464		3,705,472		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	03/26/2012	199,566	03/26/2012	182,248		3.01
3.02		06/22/2012	38,700	06/22/2012	61,701		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)		238,266		243,949		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)		5,039,730		3,949,421		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		503,568		0		6.01
6.02	SETTLEMENT TO PROGRAM		0		400,653		6.02
7.00	Total Medicare program liability (see instructions)		5,543,298		3,548,768		7.00
			0	Contractor Number	Date (Mo/Day/Yr)		
				1.00	2.00		
8.00	Name of Contractor						8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151335	Period: From 07/01/2011 To 06/30/2012	Worksheet E-3 Part V Date/Time Prepared: 11/26/2012 3:42 pm
		Title XVIII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHS)				
1.00	Inpatient services		5,987,320	1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction)		0	2.00
3.00	Organ acquisition		0	3.00
4.00	Subtotal (sum of lines 1 thru 3)		5,987,320	4.00
5.00	Primary payer payments		440	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		6,046,753	6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
7.00	Routine service charges		0	7.00
8.00	Ancillary service charges		0	8.00
9.00	Organ acquisition charges, net of revenue		0	9.00
10.00	Total reasonable charges		0	10.00
Customary charges				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)		0.000000	13.00
14.00	Total customary charges (see instructions)		0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)		0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)		0	16.00
17.00	Cost of teaching physicians (from worksheet D-5, Part II, column 3, line 20) (see instructions)		0	17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from worksheet E-4, line 49)		0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)		6,046,753	19.00
20.00	Deductibles (exclude professional component)		546,097	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20)		5,500,656	22.00
23.00	Coinsurance		5,178	23.00
24.00	Subtotal (line 22 minus line 23)		5,495,478	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		47,820	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		47,820	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		34,018	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		5,543,298	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	29.00
29.99	Recovery of Accelerated Depreciation		0	29.99
30.00	Subtotal (line 28, plus or minus lines 29)		5,543,298	30.00
31.00	Interim payments		5,039,730	31.00
32.00	Tentative settlement (for contractor use only)		0	32.00
33.00	Balance due provider/program (line 30 minus the sum of lines 31, and 32)		503,568	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151335	Period: From 07/01/2011 To 06/30/2012	Worksheet E-3 Part VII Date/Time Prepared: 11/26/2012 3:42 pm
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	Title XIX	Hospital	Cost
			1.00

PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	1,149,963	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)	1,149,963	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)	1,149,963	7.00
COMPUTATION OF LESSER OF COST OR CHARGES			
Reasonable Charges			
8.00	Routine service charges	200,389	8.00
9.00	Ancillary service charges	2,030,467	9.00
10.00	Organ acquisition charges, net of revenue	0	10.00
11.00	Incentive from target amount computation	0	11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	2,230,856	12.00
CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	15.00
16.00	Total customary charges (see instructions)	2,230,856	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	1,080,893	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)	1,149,963	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	22.00
23.00	Outlier payments	0	23.00
24.00	Program capital payments	0	24.00
25.00	Capital exception payments (see instructions)	0	25.00
26.00	Routine and Ancillary service other pass through costs	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	28.00
29.00	Titles V or XIX enter the sum of lines 27 and 21.	1,149,963	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	1,149,963	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)	1,149,963	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	37.00
38.00	Subtotal (line 36 ± line 37)	1,149,963	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)	1,149,963	40.00
41.00	Interim payments	1,149,963	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: 151335

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

Worksheet G

Date/Time Prepared:
11/26/2012 3:42 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	1,471,265	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	9,504,105	0	0	0	4.00
5.00	Other receivable	1,929,814	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-6,486,552	0	0	0	6.00
7.00	Inventory	606,054	0	0	0	7.00
8.00	Prepaid expenses	239,925	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	-31,125	31,125	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	7,233,486	31,125	0	0	11.00
FIXED ASSETS						
12.00	Land	100,000	0	0	0	12.00
13.00	Land improvements	60,000	0	0	0	13.00
14.00	Accumulated depreciation	-12,000	0	0	0	14.00
15.00	Buildings	5,863,616	0	0	0	15.00
16.00	Accumulated depreciation	-550,171	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	1,040,780	0	0	0	19.00
20.00	Accumulated depreciation	-467,600	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	2,658,400	0	0	0	23.00
24.00	Accumulated depreciation	-1,576,989	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)	7,116,036	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	811,627	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	811,627	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	15,161,149	31,125	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	551,510	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,248,186	0	0	0	38.00
39.00	Payroll taxes payable	112,471	0	0	0	39.00
40.00	Notes and loans payable (short term)	61,618	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	5,093,780	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	1,380,941	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	9,448,506	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	7,816,746	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	7,816,746	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	17,265,252	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	-2,104,103	0	0	0	52.00
53.00	Specific purpose fund	0	31,125	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	-2,104,103	31,125	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	15,161,149	31,125	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151335

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

Worksheet G-1

Date/Time Prepared:
11/26/2012 3:42 pm

	General Fund		Special Purpose Fund		
	1.00	2.00	3.00	4.00	
1.00 Fund balances at beginning of period		-972,930		0	1.00
2.00 Net income (loss) (from wkst. G-3, line 29)		-1,175,539			2.00
3.00 Total (sum of line 1 and line 2)		-2,148,469		0	3.00
4.00 TRANSFERS TO AFFILIATES	28,008		0		4.00
5.00 DEFERRED PENSION COSTS	444,460		0		5.00
6.00 DONATIONS	0		51,285		6.00
7.00 RELEASED OPERATING	60,035		0		7.00
8.00 OTHER ADDITION	0		8,750		8.00
9.00 OTHER ADJUSTMENTS	0		31,821		9.00
10.00 Total additions (sum of line 4-9)		532,503		91,856	10.00
11.00 Subtotal (line 3 plus line 10)		-1,615,966		91,856	11.00
12.00 OTHER PENSION RELATED NET ASSET ADJ.	479,387		0		12.00
13.00 OTHER ADJUSTMENTS	8,750		0		13.00
14.00 RELEASED OPERATING	0		696		14.00
15.00 RELEASED CAPITAL	0		60,035		15.00
16.00	0		0		16.00
17.00	0		0		17.00
18.00 Total deductions (sum of lines 12-17)		488,137		60,731	18.00
19.00 Fund balance at end of period per balance sheet (line 11 minus line 18)		-2,104,103		31,125	19.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151335

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

Worksheet G-1

Date/Time Prepared:
11/26/2012 3:42 pm

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 151335

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
11/26/2012 3:42 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	4,023,175		4,023,175	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	0		0	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)	4,023,175		4,023,175	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	1,382,670		1,382,670	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)	1,382,670		1,382,670	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	5,405,845		5,405,845	17.00
18.00	Ancillary services	12,399,401	39,775,140	52,174,541	18.00
19.00	Outpatient services	258,692	5,278,699	5,537,391	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		0	0	22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	COMMUNITY OUTREACH	0	462,947	462,947	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to wkst. G-3, line 1)	18,063,938	45,516,786	63,580,724	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per wkst. A, column 3, line 200)		29,512,916		29.00
30.00	BAD DEBTS	3,387,290			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		3,387,290		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to wkst. G-3, line 4)		32,900,206		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 151335

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

Worksheet G-3

Date/Time Prepared:
11/26/2012 3:42 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	63,580,724	1.00
2.00	Less contractual allowances and discounts on patients' accounts	33,240,728	2.00
3.00	Net patient revenues (line 1 minus line 2)	30,339,996	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	32,900,206	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-2,560,210	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	5,800	6.00
7.00	Income from investments	40,651	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	89,575	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	23,223	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	100,117	22.00
23.00	Governmental appropriations	445,683	23.00
24.00	GAIN ON SALE	60,417	24.00
24.01	MISC	127,342	24.01
24.02	MISC DIETARY	1,522	24.02
24.03	MISC A&G	0	24.03
24.04	OTHER INCOME	0	24.04
24.05	GAIN ON INTEREST RATE SWAPS	5,482	24.05
24.06	NON-CASH FUNDED PENSION CURTAILMENT	470,011	24.06
24.07	BUILDING RENT	32,058	24.07
25.00	Total other income (sum of lines 6-24)	1,401,881	25.00
26.00	Total (line 5 plus line 25)	-1,158,329	26.00
27.00	UNREALIZED LOSS	17,210	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	17,210	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-1,175,539	29.00