

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

**MEDICARE PROVIDER NO. 15-2020
AND MEDICAID AIM NO. 200392020A**

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

JUNE 30, 2012

ST. VINCENT SETON SPECIALTY HOSPITAL
INDIANAPOLIS, IN

MEDICARE PROVIDER NO. 15-2020
AND MEDICAID AIM NO. 200392020A

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Accountants' Disclaimer

Hospital Statements of Reimbursable Costs



Bradley Associates
Healthcare Advisors and CPAs

Board of Directors
St. Vincent Seton Specialty Hospital
Indianapolis, IN

We have compiled the Hospital Statements of Reimbursable Costs (Title XVIII and XIX) of St. Vincent Seton Specialty 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 report referred to above and, accordingly, do not express an opinion or any other form of assurance on it.

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

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

Bradley Associates

November 26, 2012

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

Provider CCN: 152020

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

Worksheet 5 Parts I-III Date/Time Prepared: 11/26/2012 1:43 pm

PART I - COST REPORT STATUS

Provider use only

1. Electronically filed cost report Date: 11/26/2012 Time: 1:43 pm

2. Manually submitted cost report

3. If this is an amended report enter the number of times the provider resubmitted this cost report

4. Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. Cost Report Status

(1) As Submitted

(2) Settled without Audit

(3) Settled with Audit

(4) Reopened

(5) Amended

6. Date Received:

7. Contractor No.

8. Initial Report for this Provider CCN

9. Final Report for this Provider CCN

10. NPR Date:

11. Contractor's Vendor Code: 4

12. If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST VINCENT SETON SPECIALTY HOSP INDY for the cost reporting period beginning 07/01/2011 and ending 06/30/2012 and to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services identified in this cost report were provided in compliance with such laws and regulations.

Encryption Information

ECR: Date: 11/26/2012 Time: 1:43 pm
 i9cijcRFYWy.FntUFEESxTVyNEupo0
 IT3kX0v1856IQ:xEixvkJNUX5nXTSc
 EYh60iiqnj07:qB2
 PI: Date: 11/26/2012 Time: 1:43 pm
 yNmhlQgfVSEnu9QBEiYSyW.sTcY970
 m8d.d0PEARixG.TJqQaFuuYhAbwJ2N
 hsr4KNYhTs0ux:am

(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	275,949	0	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	275,949	0	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: 152020	Period: From 07/01/2011 To 06/30/2012	Worksheet S-2 Part I Date/Time Prepared: 11/20/2012 4:54 pm
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		1.00	2.00	3.00	4.00					
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 8050 TOWNSHIP LINE ROAD	PO Box:		Zip Code: 46260		County: MARION		1.00		
2.00	City: INDIANAPOLIS	State: IN						2.00		
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
Hospital and Hospital-Based Component Identification:										
3.00	Hospital	ST VINCENT SETON SPECIALTY HOSP INDY	152020	26900	2	02/08/2003	N	P	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	8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00
						From:	To:			
						1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)					07/01/2011	06/30/2012		20.00	
21.00	Type of Control (see instructions)					1			21.00	
Inpatient PPS Information										
22.00	Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					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 paid days in col. 3, out-of-state Medicaid eligible days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.	0	0	0	0	0	0		25.00	
						Urban/Rural S	Date of Geogr			
						1.00	2.00			
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter (1) for urban or (2) for rural.					1			26.00	
27.00	For the Standard Geographic classification (not wage), what is your status at the end of the cost reporting period. Enter (1) for urban or (2) for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					1			27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0			35.00	
						Beginning:	Ending:			
						1.00	2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.								36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.					0			37.00	

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 152020	Period: From 07/01/2011 To 06/30/2012	Worksheet S-2 Part I Date/Time Prepared: 11/20/2012 4:54 pm		
		Beginning:	Ending:			
		1.00	2.00			
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.				38.00	
		V	XVIII	XIX		
		1.00	2.00	3.00		
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 trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)		0.00		62.00	
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)		0.00		62.01	
Teaching Hospitals that Claim Residents in Non-Provider Settings						
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)	N			63.00	
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
		1.00	2.00	3.00		
Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.						
64.00	If line 63 is yes or your facility trained residents in the base year period, enter in column 1, from your cost reporting period that begins on or after July 1, 2009, and before June 30, 2010 the number of unweighted nonprimary care FTE residents attributable to rotations that occurred in all nonprovider settings. Enter in column 2 the number of unweighted nonprimary care FTE residents that trained in your hospital. Include unweighted OB/GYN, dental and podiatry FTEs on this line. Enter in column 3, the ratio of column 1 divided by the sum of columns 1 and 2.		0.00	0.00	0.000000	64.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))
		1.00	2.00	3.00	4.00	5.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 152020

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

Worksheet S-2
Part I
Date/Time Prepared:
11/20/2012 4:54 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 Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	66.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	If line 63 is yes, then, for each primary care residency program in which you are training residents, enter in column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations that occurred in nonprovider settings for each applicable program. Enter in column 4 the number of unweighted primary care FTE residents in your hospital for each applicable program. Enter in column 5 the ratio of column 3 divided by the sum of columns 3 and 4. Use subscripted lines 67.01 through 67.50 for each additional primary care program. If you operated a primary care program that did not have FTE residents in a nonprovider setting, enter zero in column 3 and complete all other columns for each applicable program.			0.00	0.00	0.000000	67.00

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 152020	Period: From 07/01/2011 To 06/30/2012	Worksheet S-2 Part I Date/Time Prepared: 11/20/2012 4:54 pm		
		1.00	2.00	3.00		
Inpatient Psychiatric Facility PPS						
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N				70.00
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost 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.)			Y		80.00
TEFRA Providers						
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			N		86.00
				V	XIX	
				1.00	2.00	
Title V or XIX Inpatient Services						
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N		Y		90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N		Y		91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N		92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N		N		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N		N		94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00			0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N		96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00			0.00	97.00
Rural Providers						
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	N				105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	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		N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N				108.00
		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					109.00
		1.00	2.00	3.00		
Miscellaneous Cost Reporting Information						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.	N			0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 152020	Period: From 07/01/2011 To 06/30/2012	Worksheet S-2 Part I Date/Time Prepared: 11/20/2012 4:54 pm
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		1.00	2.00	3.00	
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2			118.00
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	Enter the total amount of malpractice premiums paid in column 1, enter the total amount of paid losses in column 2, and enter the total amount of self insurance paid in column 3.	28,052	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			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?	N			144.00
145.00	If costs for renal services are claimed on worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.	Y			145.00
		1.00	2.00		
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N			146.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N			147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N			148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N			149.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 152020	Period: From 07/01/2011 To 06/30/2012	Worksheet S-2 Part I Date/Time Prepared: 11/20/2012 4:54 pm
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	Part A	Part B	Title V	Title XIX	
	1.00	2.00	3.00	4.00	
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00 Hospital	N	N	N	N	155.00
156.00 Subprovider - IPF	N	N	N	N	156.00
157.00 Subprovider - IRF	N	N	N	N	157.00
158.00 SUBPROVIDER					158.00
159.00 SNF	N	N	N	N	159.00
160.00 HOME HEALTH AGENCY	N	N	N	N	160.00
161.00 CMHC		N	N	N	161.00

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 152020	Period: From 07/01/2011 To 06/30/2012	Worksheet S-2 Part II Date/Time Prepared: 11/20/2012 4:54 pm
		Y/N	Date	
		1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N	Date	V/I
		1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N		3.00
		Y/N	Type	Date
		1.00	2.00	3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
		Y/N	Legal Oper.	
		1.00	2.00	
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N		9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
		Y/N		
		1.00		
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N	14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N	15.00
		Part A		
		Description	Y/N	Date
		0	1.00	2.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	10/10/2012	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		20.00

	Description	Part A		
		Y/N	Date	
	0	1.00	2.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		21.00
				1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)				
Capital Related Cost				
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N		27.00
Interest Expense				
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	Y		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N		31.00
Purchased Services				
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N		33.00
Provider-Based Physicians				
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	N		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	N		35.00
				Y/N
				Date
				1.00
				2.00
Home Office Costs				
36.00	Were home office costs claimed on the cost report?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00
				1.00
				2.00
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	GARY	MARKER	41.00
42.00	Enter the employer/company name of the cost report preparer.	ST. VINCENT HEALTH		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-583-3232	GAMARKER@STVINCENT.ORG	43.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 152020

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

Worksheet S-3
Part I
Date/Time Prepared:
11/20/2012 4:54 pm

Cost Center Description	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	
	Line Number				
	1.00	2.00	3.00	4.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	74	27,084	0.00	1.00
2.00 HMO					2.00
3.00 HMO IPF					3.00
4.00 HMO IRF					4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					5.00
6.00 Hospital Adults & Peds. Swing Bed NF					6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		74	27,084	0.00	7.00
8.00 INTENSIVE CARE UNIT					8.00
9.00 CORONARY CARE UNIT					9.00
10.00 BURN INTENSIVE CARE UNIT					10.00
11.00 SURGICAL INTENSIVE CARE UNIT					11.00
12.00 OTHER SPECIAL CARE (SPECIFY)					12.00
13.00 NURSERY					13.00
14.00 Total (see instructions)		74	27,084	0.00	14.00
15.00 CAH visits					15.00
16.00 SUBPROVIDER - IPF					16.00
17.00 SUBPROVIDER - IRF					17.00
18.00 SUBPROVIDER					18.00
19.00 SKILLED NURSING FACILITY					19.00
20.00 NURSING FACILITY					20.00
21.00 OTHER LONG TERM CARE					21.00
22.00 HOME HEALTH AGENCY					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)					23.00
24.00 HOSPICE					24.00
25.00 CMHC - CMHC					25.00
26.00 RURAL HEALTH CLINIC					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER					26.25
27.00 Total (sum of lines 14-26)		74			27.00
28.00 Observation Bed Days					28.00
29.00 Ambulance Trips					29.00
30.00 Employee discount days (see instruction)					30.00
31.00 Employee discount days - IRF					31.00
32.00 Labor & delivery days (see instructions)					32.00
33.00 LTCH non-covered days					33.00

Cost Center Description	I/P Days / O/P Visits / Trips					
	Title V	Title XVIII	Title XIX	Total All Patients		
	5.00	6.00	7.00	8.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	0	14,666	284	22,415		1.00
2.00 HMO		2,323	0			2.00
3.00 HMO IPF		0	0			3.00
4.00 HMO IRF		0	0			4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0	0		5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0		0	0		6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	0	14,666	284	22,415		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	14,666	284	22,415		14.00
15.00 CAH visits	0	0	0	0		15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)						27.00
28.00 Observation Bed Days	0		0	0		28.00
29.00 Ambulance Trips		0				29.00
30.00 Employee discount days (see instruction)				0		30.00
31.00 Employee discount days - IRF				0		31.00
32.00 Labor & delivery days (see instructions)			0	0		32.00
33.00 LTCH non-covered days		0				33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 152020

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

Worksheet S-3
Part I
Date/Time Prepared:
11/20/2012 4:54 pm

Cost Center Description	Full Time Equivalents			Discharges		
	Total Interns & Residents	Employees On Payroll	Nonpaid workers	Title V	Title XVIII	
	9.00	10.00	11.00	12.00	13.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)				0	457	1.00
2.00 HMO					84	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	309.88	0.00	0	457	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)	0.00	309.88	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)	11	724		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)	11	724		14.00
15.00 CAH visits				15.00
16.00 SUBPROVIDER - IPF				16.00
17.00 SUBPROVIDER - IRF				17.00
18.00 SUBPROVIDER				18.00
19.00 SKILLED NURSING FACILITY				19.00
20.00 NURSING FACILITY				20.00
21.00 OTHER LONG TERM CARE				21.00
22.00 HOME HEALTH AGENCY				22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)				23.00
24.00 HOSPICE				24.00
25.00 CMHC - CMHC				25.00
26.00 RURAL HEALTH CLINIC				26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER				26.25
27.00 Total (sum of lines 14-26)				27.00
28.00 Observation Bed Days				28.00
29.00 Ambulance Trips				29.00
30.00 Employee discount days (see instruction)				30.00
31.00 Employee discount days - IRF				31.00
32.00 Labor & delivery days (see instructions)				32.00
33.00 LTCH non-covered days				33.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 152020

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

Worksheet A

Date/Time Prepared:
11/20/2012 4:54 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100		1,128,671	1,128,671	-1,950	1,126,721	1.00
2.00	00200		1,009,466	1,009,466	0	1,009,466	2.00
3.00	00300		0	0	0	0	3.00
4.00	00400	420,353	5,003,848	5,424,201	0	5,424,201	4.00
5.00	00500	2,767,405	2,438,081	5,205,486	1,950	5,207,436	5.00
6.00	00600	0	0	0	0	0	6.00
7.00	00700	392,377	868,499	1,260,876	0	1,260,876	7.00
9.00	00901	154,964	323,281	478,245	0	478,245	9.00
10.00	01000	232,111	475,856	707,967	0	707,967	10.00
11.00	01100	0	0	0	0	0	11.00
12.00	01200	0	0	0	0	0	12.00
13.00	01300	919,724	6,141	925,865	0	925,865	13.00
14.00	01400	0	0	0	0	0	14.00
15.00	01500	1,516,563	2,584,764	4,101,327	0	4,101,327	15.00
16.00	01600	122,379	160,674	283,053	0	283,053	16.00
17.00	01700	123,387	832	124,219	0	124,219	17.00
17.01	01702	90,672	1,919	92,591	0	92,591	17.01
18.00	01850	0	0	0	0	0	18.00
19.00	01900	0	0	0	0	0	19.00
20.00	02000	0	0	0	0	0	20.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
23.00	02300	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	8,130,845	2,013,096	10,143,941	0	10,143,941	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	145,810	261,366	407,176	0	407,176	50.00
51.00	05100	0	0	0	0	0	51.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	172,804	262,342	435,146	0	435,146	54.00
55.00	05500	0	0	0	0	0	55.00
56.00	05600	0	0	0	0	0	56.00
57.00	05700	134,325	3,534	137,859	0	137,859	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	0	785,825	785,825	0	785,825	60.00
60.01	06001	0	0	0	0	0	60.01
61.00	06100	0	0	0	0	0	61.00
62.00	06200	0	0	0	0	0	62.00
63.00	06300	0	121,787	121,787	0	121,787	63.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	2,310,125	1,551,744	3,861,869	0	3,861,869	65.00
66.00	06600	478,513	96,987	575,500	0	575,500	66.00
67.00	06700	326,590	24,764	351,354	0	351,354	67.00
68.00	06800	154,112	362	154,474	0	154,474	68.00
69.00	06900	175,633	3,351	178,984	0	178,984	69.00
70.00	07000	1,028	245	1,273	0	1,273	70.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
74.00	07400	0	670,307	670,307	0	670,307	74.00
75.00	07500	0	0	0	0	0	75.00
SPECIAL PURPOSE COST CENTERS							
118.00		18,769,720	19,797,742	38,567,462	0	38,567,462	118.00
NONREIMBURSABLE COST CENTERS							
193.00	19300	0	0	0	0	0	193.00
193.01	19302	0	0	0	0	0	193.01
200.00		18,769,720	19,797,742	38,567,462	0	38,567,462	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 152020

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

Worksheet A

Date/Time Prepared:
11/20/2012 4:54 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	471,159	1,597,880	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	1,009,466	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS	239,804	5,664,005	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	350,426	5,557,862	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700	OPERATION OF PLANT	21,143	1,282,019	7.00
9.00	00901	HOUSEKEEPING	0	478,245	9.00
10.00	01000	DIETARY	-128,659	579,308	10.00
11.00	01100	CAFETERIA	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	925,865	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	14.00
15.00	01500	PHARMACY	0	4,101,327	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-8,927	274,126	16.00
17.00	01700	SOCIAL SERVICE	0	124,219	17.00
17.01	01702	PASTORAL CARE	0	92,591	17.01
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-732	10,143,209	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	407,176	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	435,146	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	137,859	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	785,825	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	121,787	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	3,861,869	65.00
66.00	06600	PHYSICAL THERAPY	0	575,500	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	351,354	67.00
68.00	06800	SPEECH PATHOLOGY	0	154,474	68.00
69.00	06900	ELECTROCARDIOLOGY	0	178,984	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,273	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	670,307	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	75.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	944,214	39,511,676	118.00
NONREIMBURSABLE COST CENTERS					
193.00	19300	NONPAID WORKERS	0	0	193.00
193.01	19302	MARKETING	548,039	548,039	193.01
200.00		TOTAL (SUM OF LINES 118-199)	1,492,253	40,059,715	200.00

Provider CCN: 152020

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

Worksheet A-6
Date/Time Prepared:
11/20/2012 4:54 pm

		Increases				
Cost Center		Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
A - INTEREST						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,950		1.00
	TOTALS		0	1,950		
500.00	Grand Total: Increases		0	1,950		500.00

Provider CCN: 152020

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

Worksheet A-6
Date/Time Prepared:
11/20/2012 4:54 pm

Decreases						Wkst. A-7 Ref.	
Cost Center	Line #	Salary	Other				
6.00	7.00	8.00	9.00	10.00			
A - INTEREST							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,950	9		1.00
TOTALS			0	1,950			
500.00	Grand Total: Decreases		0	1,950			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 152020

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
11/20/2012 4:54 pm

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	847,629	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	2.00
3.00	Buildings and Fixtures	21,163,628	0	0	147,924	3.00
4.00	Building Improvements	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	5.00
6.00	Movable Equipment	0	0	0	0	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	22,011,257	0	0	147,924	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	22,011,257	0	0	147,924	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	932,673	161,239	15,779	14,572	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	323,457	684,623	0	1,386	2.00
3.00	Total (sum of lines 1-2)	1,256,130	845,862	15,779	15,958	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	15,971,480	0	15,971,480	0.759978	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	5,044,224	0	5,044,224	0.240022	2.00
3.00	Total (sum of lines 1-2)	21,015,704	0	21,015,704	1.000000	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 152020

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
11/20/2012 4:54 pm

		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	847,629	0		1.00		
2.00	Land Improvements	0	0		2.00		
3.00	Buildings and Fixtures	21,015,704	0		3.00		
4.00	Building Improvements	0	0		4.00		
5.00	Fixed Equipment	0	0		5.00		
6.00	Movable Equipment	0	0		6.00		
7.00	HIT designated Assets	0	0		7.00		
8.00	Subtotal (sum of lines 1-7)	21,863,333	0		8.00		
9.00	Reconciling Items	0	0		9.00		
10.00	Total (line 8 minus line 9)	21,863,333	0		10.00		
SUMMARY OF CAPITAL							
Cost Center Description		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	1,128,671		1.00		
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,009,466		2.00		
3.00	Total (sum of lines 1-2)	0	2,138,137		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	1,403,491	161,239	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	323,457	684,623	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,726,948	845,862	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 152020

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
11/20/2012 4:54 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	14,170	14,572	4,408	0	1,597,880	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,386	0	0	1,009,466	2.00
3.00	Total (sum of lines 1-2)	14,170	15,958	4,408	0	2,607,346	3.00

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on worksheet A To/From Which the Amount is to be Adjusted		
			Cost Center		Line #
			1.00	2.00	3.00
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-12,520	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	-1,728	ADMINISTRATIVE & GENERAL	5.00	3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0		0.00	4.00
5.00 Refunds and rebates of expenses (chapter 8)		0		0.00	5.00
6.00 Rental of provider space by suppliers (chapter 8)		0		0.00	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0		0.00	7.00
8.00 Television and radio service (chapter 21)		0		0.00	8.00
9.00 Parking lot (chapter 21)		0		0.00	9.00
10.00 Provider-based physician adjustment	A-8-2	0			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	1,755,302			12.00
13.00 Laundry and linen service		0		0.00	13.00
14.00 Cafeteria-employees and guests	B	-128,659	DIETARY	10.00	14.00
15.00 Rental of quarters to employee and others		0		0.00	15.00
16.00 Sale of medical and surgical supplies to other than patients		0		0.00	16.00
17.00 Sale of drugs to other than patients		0		0.00	17.00
18.00 Sale of medical records and abstracts		0		0.00	18.00
19.00 Nursing school (tuition, fees, books, etc.)		0		0.00	19.00
20.00 Vending machines		0		0.00	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00	23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00	24.00
25.00 Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00	25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	27.00
28.00 Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00	28.00
29.00 Physicians' assistant		0		0.00	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00	30.00
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00	31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0		0.00	32.00
33.00 MEDICAL RECORDS INCOME	B	-8,927	MEDICAL RECORDS & LIBRARY	16.00	33.00
33.01 MISCELLANEOUS INCOME	B	-2,788	ADMINISTRATIVE & GENERAL	5.00	33.01
33.02 MAINTENANCE INCOME	B	-3,350	OPERATION OF PLANT	7.00	33.02
33.03 NURSING INCOME	B	338	ADULTS & PEDIATRICS	30.00	33.03
33.04 LOBBYING - NALTH	A	-643	ADMINISTRATIVE & GENERAL	5.00	33.04
33.05 LOBBYING - HOME OFFICE	A	-893	ADMINISTRATIVE & GENERAL	5.00	33.05
33.06 BUSINESS ACQUISITION ANALYSIS	A	-16,102	ADMINISTRATIVE & GENERAL	5.00	33.06
33.07 LOSS ON FIXED ASSETS	A	-761	ADULTS & PEDIATRICS	30.00	33.07
33.08 NON-REIMBURSABLE ALCOHOL	A	-71	ADMINISTRATIVE & GENERAL	5.00	33.08
33.09 CHARITY	A	-11,846	ADMINISTRATIVE & GENERAL	5.00	33.09
33.10 LOSS ON FIXED ASSETS	A	-5,196	ADMINISTRATIVE & GENERAL	5.00	33.10
33.11 DONATIONS	A	-309	ADULTS & PEDIATRICS	30.00	33.11
33.12 INCENTIVE PAYROLL ADJ.	A	-64,626	ADMINISTRATIVE & GENERAL	5.00	33.12
33.13 INCENTIVE PAYROLL ADJ.	A	-4,968	EMPLOYEE BENEFITS	4.00	33.13
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200.)		1,492,253			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	MEDICAL RECORDS INCOME	0	33.00
33.01	MISCELLANEOUS INCOME	0	33.01
33.02	MAINTENANCE INCOME	0	33.02
33.03	NURSING INCOME	0	33.03
33.04	LOBBYING - NALTH	0	33.04
33.05	LOBBYING - HOME OFFICE	0	33.05
33.06	BUSINESS ACQUISITION ANALYSIS	0	33.06
33.07	LOSS ON FIXED ASSETS	0	33.07
33.08	NON-REIMBURSABLE ALCOHOL	0	33.08
33.09	CHARITY	0	33.09
33.10	LOSS ON FIXED ASSETS	0	33.10
33.11	DONATIONS	0	33.11
33.12	INCENTIVE PAYROLL ADJ.	0	33.12
33.13	INCENTIVE PAYROLL ADJ.	0	33.13
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		50.00

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

Provider CCN: 152020

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

Worksheet A-8-1

Date/Time Prepared:
11/20/2012 4:54 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		4.00	EMPLOYEE BENEFITS	EMPLOYEE BENEFITS CHARGEBACK	1.00
2.00		5.00	ADMINISTRATIVE & GENERAL	A&G CHARGEBACK	2.00
3.00		7.00	OPERATION OF PLANT	PLANT OPS CHARGEBACK	3.00
4.00		10.00	DIETARY	DIETARY CHARGEBACK	4.00
4.01		14.00	CENTRAL SERVICES & SUPPLY	CENTRAL SVCS CHARGEBACK	4.01
4.02		15.00	PHARMACY	PHARMACY CHARGEBACK	4.02
4.03		16.00	MEDICAL RECORDS & LIBRARY	MED RECS & LIB CHARGEBACK	4.03
4.04		18.00	OTHER GENERAL SERVICE (SPECIFY)	PASTORAL CARE CHARGEBACK	4.04
4.05		30.00	ADULTS & PEDIATRICS	ADULTS & PEDS CHARGEBACK	4.05
4.06		50.00	OPERATING ROOM	OPERATING ROOM CHARGEBACK	4.06
4.07		54.00	RADIOLOGY-DIAGNOSTIC	RADIOLOGY CHARGEBACK	4.07
4.08		60.00	LABORATORY	LABORATORY CHARGEBACK	4.08
4.09		65.00	RESPIRATORY THERAPY	RT CHARGEBACK	4.09
4.10		66.00	PHYSICAL THERAPY	PT CHARGEBACK	4.10
4.11		67.00	OCCUPATIONAL THERAPY	OT CHARGEBACK	4.11
4.12		68.00	SPEECH PATHOLOGY	ST CHARGEBACK	4.12
4.13		69.00	ELECTROCARDIOLOGY	EKG CHARGEBACK	4.13
4.14		70.00	ELECTROENCEPHALOGRAPHY	EEG CHARGEBACK	4.14
4.15		74.00	RENAL DIALYSIS	RENAL DIALYSIS CHARGEBACK	4.15
4.16		1.00	CAP REL COSTS-BLDG & FIXT	ST. VINCENT HEALTH CAPITAL	4.16
4.17		5.00	ADMINISTRATIVE & GENERAL	ST VINCENT HEALTH A&G	4.17
4.18		193.01	MARKETING	ST VINCENT HEALTH MARKETING	4.18
4.19		4.00	EMPLOYEE BENEFITS	ASCENSION PENSION PLAN	4.19
4.20		1.00	CAP REL COSTS-BLDG & FIXT	ASCENSION INTEREST	4.20
4.21		5.00	ADMINISTRATIVE & GENERAL	ASCENSION INTEREST	4.21
4.22		4.00	EMPLOYEE BENEFITS	ST VINCENT HEALTH SELF INSURANCE	4.22
4.23		7.00	OPERATION OF PLANT	HOME OFFICE COSTS - TRIMEDIX	4.23
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to worksheet A-8, column 2, line 12.				5.00

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

		Symbol (1)	Name	Percentage of Ownership	
		1.00	2.00	3.00	

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

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

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

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

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS
 Provider CCN: 152020
 Period: From 07/01/2011 To 06/30/2012
 Worksheet A-8-1
 Date/Time Prepared: 11/20/2012 4:54 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	347,761	347,761	0	0	1.00
2.00	327,268	327,268	0	0	2.00
3.00	2,729	2,729	0	0	3.00
4.00	233,287	233,287	0	0	4.00
4.01	363	363	0	0	4.01
4.02	48,961	48,961	0	0	4.02
4.03	181,768	181,768	0	0	4.03
4.04	90,672	90,672	0	0	4.04
4.05	139,715	139,715	0	0	4.05
4.06	150,864	150,864	0	0	4.06
4.07	463,761	463,761	0	0	4.07
4.08	31,518	31,518	0	0	4.08
4.09	18,278	18,278	0	0	4.09
4.10	1,379	1,379	0	0	4.10
4.11	75	75	0	0	4.11
4.12	262	262	0	0	4.12
4.13	3,351	3,351	0	0	4.13
4.14	245	245	0	0	4.14
4.15	4,591	4,591	0	0	4.15
4.16	485,288	0	485,288	9	4.16
4.17	2,864,869	2,410,328	454,541	0	4.17
4.18	548,039	0	548,039	0	4.18
4.19	0	390,114	-390,114	0	4.19
4.20	12,520	14,129	-1,609	11	4.20
4.21	1,728	1,950	-222	0	4.21
4.22	2,664,652	2,029,766	634,886	0	4.22
4.23	247,424	222,931	24,493	0	4.23
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to worksheet A-8, column 2, line 12.	8,871,368	7,116,066	1,755,302	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 HEAL	100.00	HOME OFFICE	6.00
7.00	ASCENSION	100.00	HOME OFFICE	7.00
8.00		0.00		8.00
9.00		0.00		9.00
10.00		0.00		10.00
100.00	G. Other (financial or non-financial) specify:			100.00

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

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

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 152020

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

Worksheet B
Part I
Date/Time Prepared:
11/20/2012 4:54 pm

Cost Center Description	Net Expenses for Cost Allocation (from wkst A col. 7)	CAPITAL RELATED COSTS:		EMPLOYEE BENEFITS	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
		1.00	2.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	1,597,880	1,597,880			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	1,009,466		1,009,466		2.00
4.00 00400	EMPLOYEE BENEFITS	5,664,005	0	0	5,664,005	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	5,557,862	38,807	24,517	854,232	6,475,418
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	0
7.00 00700	OPERATION OF PLANT	1,282,019	127,053	80,266	121,117	1,610,455
9.00 00901	HOUSEKEEPING	478,245	33,337	21,061	47,834	580,477
10.00 01000	DIETARY	579,308	69,255	43,752	71,647	763,962
11.00 01100	CAFETERIA	0	0	0	0	0
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00 01300	NURSING ADMINISTRATION	925,865	112,707	71,203	283,897	1,393,672
14.00 01400	CENTRAL SERVICES & SUPPLY	0	6,089	3,847	0	9,936
15.00 01500	PHARMACY	4,101,327	40,665	25,690	468,127	4,635,809
16.00 01600	MEDICAL RECORDS & LIBRARY	274,126	18,475	11,672	37,775	342,048
17.00 01700	SOCIAL SERVICE	124,219	10,149	6,412	38,087	178,867
17.01 01702	PASTORAL CARE	92,591	12,523	7,911	27,988	141,013
18.00 01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
20.00 02000	NURSING SCHOOL	0	0	0	0	0
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0
23.00 02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	10,143,209	1,044,908	660,125	2,509,793	14,358,035
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	407,176	6,158	3,891	45,008	462,233
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	435,146	22,018	13,910	53,340	524,414
55.00 05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0
56.00 05600	RADIOISOTOPE	0	0	0	0	0
57.00 05700	CT SCAN	137,859	5,849	3,695	41,463	188,866
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	785,825	4,782	3,021	0	793,628
60.01 06001	BLOOD LABORATORY	0	0	0	0	0
61.00 06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	121,787	0	0	0	121,787
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00 06500	RESPIRATORY THERAPY	3,861,869	8,670	5,477	713,080	4,589,096
66.00 06600	PHYSICAL THERAPY	575,500	12,145	7,672	147,705	743,022
67.00 06700	OCCUPATIONAL THERAPY	351,354	12,145	7,672	100,810	471,981
68.00 06800	SPEECH PATHOLOGY	154,474	12,145	7,672	47,571	221,862
69.00 06900	ELECTROCARDIOLOGY	178,984	0	0	54,214	233,198
70.00 07000	ELECTROENCEPHALOGRAPHY	1,273	0	0	317	1,590
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
74.00 07400	RENAL DIALYSIS	670,307	0	0	0	670,307
75.00 07500	ASC (NON-DISTINCT PART)	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	39,511,676	1,597,880	1,009,466	5,664,005	39,511,676
NONREIMBURSABLE COST CENTERS						
193.00 19300	NONPAID WORKERS	0	0	0	0	0
193.01 19302	MARKETING	548,039	0	0	0	548,039
200.00	Cross Foot Adjustments					0
201.00	Negative Cost Centers					0
202.00	TOTAL (sum lines 118-201)	40,059,715	1,597,880	1,009,466	5,664,005	40,059,715

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 152020

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

Worksheet B
Part I
Date/Time Prepared:
11/20/2012 4:54 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	HOUSEKEEPING	DIETARY	
		5.00	6.00	7.00	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	6,475,418				5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0			6.00
7.00	00700	OPERATION OF PLANT	310,513	0	1,920,968		7.00
9.00	00901	HOUSEKEEPING	111,922	0	44,720	737,119	9.00
10.00	01000	DIETARY	147,300	0	92,901	36,498	1,040,661
11.00	01100	CAFETERIA	0	0	0	0	0
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	268,715	0	151,189	59,397	0
14.00	01400	CENTRAL SERVICES & SUPPLY	1,916	0	8,169	3,209	0
15.00	01500	PHARMACY	893,835	0	54,550	21,431	0
16.00	01600	MEDICAL RECORDS & LIBRARY	65,951	0	24,783	9,736	0
17.00	01700	SOCIAL SERVICE	34,488	0	13,614	5,349	0
17.01	01702	PASTORAL CARE	27,189	0	16,799	6,600	0
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
20.00	02000	NURSING SCHOOL	0	0	0	0	0
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,768,383	0	1,401,682	550,679	1,040,661
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	89,124	0	8,261	3,245	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	101,113	0	29,536	11,604	0
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0
56.00	05600	RADIOISOTOPE	0	0	0	0	0
57.00	05700	CT SCAN	36,415	0	7,846	3,082	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	153,020	0	6,415	2,520	0
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	23,482	0	0	0	0
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	884,828	0	11,630	4,569	0
66.00	06600	PHYSICAL THERAPY	143,263	0	16,291	6,400	0
67.00	06700	OCCUPATIONAL THERAPY	91,003	0	16,291	6,400	0
68.00	06800	SPEECH PATHOLOGY	42,777	0	16,291	6,400	0
69.00	06900	ELECTROCARDIOLOGY	44,963	0	0	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	307	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
74.00	07400	RENAL DIALYSIS	129,243	0	0	0	0
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	6,369,750	0	1,920,968	737,119	1,040,661
NONREIMBURSABLE COST CENTERS							
193.00	19300	NONPAID WORKERS	0	0	0	0	0
193.01	19302	MARKETING	105,668	0	0	0	0
200.00		Cross Foot Adjustments	0	0	0	0	0
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	6,475,418	0	1,920,968	737,119	1,040,661

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 152020

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

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description		CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		11.00	12.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
9.00	00901						9.00
10.00	01000						10.00
11.00	01100	0					11.00
12.00	01200	0	0				12.00
13.00	01300	0	0	1,872,973			13.00
14.00	01400	0	0	0	23,230		14.00
15.00	01500	0	0	0	0	5,605,625	15.00
16.00	01600	0	0	0	0	0	16.00
17.00	01700	0	0	0	0	0	17.00
17.01	01702	0	0	0	0	0	17.01
18.00	01850	0	0	0	0	0	18.00
19.00	01900	0	0	0	0	0	19.00
20.00	02000	0	0	0	0	0	20.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
23.00	02300	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	0	0	1,356,205	0	0	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	0	0	0	0	50.00
51.00	05100	0	0	0	0	0	51.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	0	0	0	0	0	54.00
55.00	05500	0	0	0	0	0	55.00
56.00	05600	0	0	0	0	0	56.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	0	0	0	0	0	60.00
60.01	06001	0	0	0	0	0	60.01
61.00	06100	0	0	0	0	0	61.00
62.00	06200	0	0	0	0	0	62.00
63.00	06300	0	0	0	0	0	63.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	0	0	362,268	23,230	0	65.00
66.00	06600	0	0	80,846	0	0	66.00
67.00	06700	0	0	52,534	0	0	67.00
68.00	06800	0	0	21,120	0	0	68.00
69.00	06900	0	0	0	0	0	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	5,605,625	73.00
74.00	07400	0	0	0	0	0	74.00
75.00	07500	0	0	0	0	0	75.00
SPECIAL PURPOSE COST CENTERS							
118.00		0	0	1,872,973	23,230	5,605,625	118.00
NONREIMBURSABLE COST CENTERS							
193.00	19300	0	0	0	0	0	193.00
193.01	19302	0	0	0	0	0	193.01
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		0	0	1,872,973	23,230	5,605,625	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 152020

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

Worksheet B
Part I
Date/Time Prepared:
11/20/2012 4:54 pm

Cost Center Description		MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	PASTORAL CARE	OTHER GENERAL SERVICE (SPECIFY)	NONPHYSICIAN ANESTHETISTS	
					18.00		
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
9.00	00901	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
12.00	01200	MAINTENANCE OF PERSONNEL					12.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	442,518				16.00
17.00	01700	SOCIAL SERVICE	0	232,318			17.00
17.01	01702	PASTORAL CARE	0	0	191,601		17.01
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	442,518	232,318	191,601	0	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	442,518	232,318	191,601	0	118.00
NONREIMBURSABLE COST CENTERS							
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
193.01	19302	MARKETING	0	0	0	0	193.01
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	442,518	232,318	191,601	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 152020

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

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Cost Center Description	NURSING SCHOOL	INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	
		SERVICES-SALAR Y & FRINGES	SERVICES-OTHER PRGM COSTS			
		20.00	21.00			
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
6.00	00600	MAINTENANCE & REPAIRS				6.00
7.00	00700	OPERATION OF PLANT				7.00
9.00	00901	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
12.00	01200	MAINTENANCE OF PERSONNEL				12.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
17.01	01702	PASTORAL CARE				17.01
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)				18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
20.00	02000	NURSING SCHOOL	0			20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	22,342,082
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	562,863
51.00	05100	RECOVERY ROOM	0	0	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0
53.00	05300	ANESTHESIOLOGY	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	666,667
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0
56.00	05600	RADIOISOTOPE	0	0	0	0
57.00	05700	CT SCAN	0	0	0	236,209
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0
60.00	06000	LABORATORY	0	0	0	955,583
60.01	06001	BLOOD LABORATORY	0	0	0	0
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	145,269
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	0	0	0	5,875,621
66.00	06600	PHYSICAL THERAPY	0	0	0	989,822
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	638,209
68.00	06800	SPEECH PATHOLOGY	0	0	0	308,450
69.00	06900	ELECTROCARDIOLOGY	0	0	0	278,161
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	1,897
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	5,605,625
74.00	07400	RENAL DIALYSIS	0	0	0	799,550
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	0	0	39,406,008
NONREIMBURSABLE COST CENTERS						
193.00	19300	NONPAID WORKERS	0	0	0	0
193.01	19302	MARKETING	0	0	0	653,707
200.00		Cross Foot Adjustments	0	0	0	0
201.00		Negative Cost Centers	0	0	0	0
202.00		TOTAL (sum lines 118-201)	0	0	0	40,059,715

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 152020

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

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Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
6.00	00600	MAINTENANCE & REPAIRS		6.00
7.00	00700	OPERATION OF PLANT		7.00
9.00	00901	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
12.00	01200	MAINTENANCE OF PERSONNEL		12.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE		17.00
17.01	01702	PASTORAL CARE		17.01
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)		18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS		19.00
20.00	02000	NURSING SCHOOL		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)		23.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	22,342,082
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	562,863
51.00	05100	RECOVERY ROOM	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0
53.00	05300	ANESTHESIOLOGY	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	666,667
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0
56.00	05600	RADIOISOTOPE	0	0
57.00	05700	CT SCAN	0	236,209
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0
60.00	06000	LABORATORY	0	955,583
60.01	06001	BLOOD LABORATORY	0	0
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	145,269
64.00	06400	INTRAVENOUS THERAPY	0	0
65.00	06500	RESPIRATORY THERAPY	0	5,875,621
66.00	06600	PHYSICAL THERAPY	0	989,822
67.00	06700	OCCUPATIONAL THERAPY	0	638,209
68.00	06800	SPEECH PATHOLOGY	0	308,450
69.00	06900	ELECTROCARDIOLOGY	0	278,161
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,897
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,605,625
74.00	07400	RENAL DIALYSIS	0	799,550
75.00	07500	ASC (NON-DISTINCT PART)	0	0
SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	39,406,008
NONREIMBURSABLE COST CENTERS				
193.00	19300	NONPAID WORKERS	0	0
193.01	19302	MARKETING	0	653,707
200.00		Cross Foot Adjustments	0	0
201.00		Negative Cost Centers	0	0
202.00		TOTAL (sum lines 118-201)	0	40,059,715

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 152020

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

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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS
		BLDG & FIXT	MVBLE EQUIP		
		0	1.00		
GENERAL SERVICE COST CENTERS					
1.00 00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00 00400	EMPLOYEE BENEFITS	0	0	0	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	38,807	24,517	5.00
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	6.00
7.00 00700	OPERATION OF PLANT	0	127,053	80,266	7.00
9.00 00901	HOUSEKEEPING	0	33,337	21,061	9.00
10.00 01000	DIETARY	0	69,255	43,752	10.00
11.00 01100	CAFETERIA	0	0	0	11.00
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	12.00
13.00 01300	NURSING ADMINISTRATION	0	112,707	71,203	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	6,089	3,847	14.00
15.00 01500	PHARMACY	0	40,665	25,690	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	18,475	11,672	16.00
17.00 01700	SOCIAL SERVICE	0	10,149	6,412	17.00
17.01 01702	PASTORAL CARE	0	12,523	7,911	17.01
18.00 01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	18.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	19.00
20.00 02000	NURSING SCHOOL	0	0	0	20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	22.00
23.00 02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 03000	ADULTS & PEDIATRICS	0	1,044,908	660,125	30.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000	OPERATING ROOM	0	6,158	3,891	50.00
51.00 05100	RECOVERY ROOM	0	0	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00 05300	ANESTHESIOLOGY	0	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	22,018	13,910	54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	0	0	0	55.00
56.00 05600	RADIOISOTOPE	0	0	0	56.00
57.00 05700	CT SCAN	0	5,849	3,695	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	59.00
60.00 06000	LABORATORY	0	4,782	3,021	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	60.01
61.00 06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	61.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	62.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	63.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	0	8,670	5,477	65.00
66.00 06600	PHYSICAL THERAPY	0	12,145	7,672	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	12,145	7,672	67.00
68.00 06800	SPEECH PATHOLOGY	0	12,145	7,672	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	0	0	0	74.00
75.00 07500	ASC (NON-DISTINCT PART)	0	0	0	75.00
SPECIAL PURPOSE COST CENTERS					
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	1,597,880	1,009,466	118.00
NONREIMBURSABLE COST CENTERS					
193.00 19300	NONPAID WORKERS	0	0	0	193.00
193.01 19302	MARKETING	0	0	0	193.01
200.00	Cross Foot Adjustments				200.00
201.00	Negative Cost Centers		0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	1,597,880	1,009,466	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 152020

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

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Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	HOUSEKEEPING	DIETARY	
		5.00	6.00	7.00	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	63,324					5.00
6.00	00600	0	0				6.00
7.00	00700	3,037	0	210,356			7.00
9.00	00901	1,095	0	4,897	60,390		9.00
10.00	01000	1,441	0	10,173	2,990	127,611	10.00
11.00	01100	0	0	0	0	0	11.00
12.00	01200	0	0	0	0	0	12.00
13.00	01300	2,628	0	16,556	4,866	0	13.00
14.00	01400	19	0	895	263	0	14.00
15.00	01500	8,743	0	5,973	1,756	0	15.00
16.00	01600	645	0	2,714	798	0	16.00
17.00	01700	337	0	1,491	438	0	17.00
17.01	01702	266	0	1,840	541	0	17.01
18.00	01850	0	0	0	0	0	18.00
19.00	01900	0	0	0	0	0	19.00
20.00	02000	0	0	0	0	0	20.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
23.00	02300	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	27,064	0	153,491	45,116	127,611	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	872	0	905	266	0	50.00
51.00	05100	0	0	0	0	0	51.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	989	0	3,234	951	0	54.00
55.00	05500	0	0	0	0	0	55.00
56.00	05600	0	0	0	0	0	56.00
57.00	05700	356	0	859	253	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	1,497	0	702	206	0	60.00
60.01	06001	0	0	0	0	0	60.01
61.00	06100	0	0	0	0	0	61.00
62.00	06200	0	0	0	0	0	62.00
63.00	06300	230	0	0	0	0	63.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	8,655	0	1,274	374	0	65.00
66.00	06600	1,401	0	1,784	524	0	66.00
67.00	06700	890	0	1,784	524	0	67.00
68.00	06800	418	0	1,784	524	0	68.00
69.00	06900	440	0	0	0	0	69.00
70.00	07000	3	0	0	0	0	70.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
74.00	07400	1,264	0	0	0	0	74.00
75.00	07500	0	0	0	0	0	75.00
SPECIAL PURPOSE COST CENTERS							
118.00		62,290	0	210,356	60,390	127,611	118.00
NONREIMBURSABLE COST CENTERS							
193.00	19300	0	0	0	0	0	193.00
193.01	19302	1,034	0	0	0	0	193.01
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		63,324	0	210,356	60,390	127,611	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 152020

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

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Cost Center Description		CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		11.00	12.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
9.00	00901						9.00
10.00	01000						10.00
11.00	01100	0					11.00
12.00	01200	0	0				12.00
13.00	01300	0	0	207,960			13.00
14.00	01400	0	0	0	11,113		14.00
15.00	01500	0	0	0	0	82,827	15.00
16.00	01600	0	0	0	0	0	16.00
17.00	01700	0	0	0	0	0	17.00
17.01	01702	0	0	0	0	0	17.01
18.00	01850	0	0	0	0	0	18.00
19.00	01900	0	0	0	0	0	19.00
20.00	02000	0	0	0	0	0	20.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
23.00	02300	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	0	0	150,583	0	0	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	0	0	0	0	50.00
51.00	05100	0	0	0	0	0	51.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	0	0	0	0	0	54.00
55.00	05500	0	0	0	0	0	55.00
56.00	05600	0	0	0	0	0	56.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	0	0	0	0	0	60.00
60.01	06001	0	0	0	0	0	60.01
61.00	06100	0	0	0	0	0	61.00
62.00	06200	0	0	0	0	0	62.00
63.00	06300	0	0	0	0	0	63.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	0	0	40,223	11,113	0	65.00
66.00	06600	0	0	8,976	0	0	66.00
67.00	06700	0	0	5,833	0	0	67.00
68.00	06800	0	0	2,345	0	0	68.00
69.00	06900	0	0	0	0	0	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	82,827	73.00
74.00	07400	0	0	0	0	0	74.00
75.00	07500	0	0	0	0	0	75.00
SPECIAL PURPOSE COST CENTERS							
118.00		0	0	207,960	11,113	82,827	118.00
NONREIMBURSABLE COST CENTERS							
193.00	19300	0	0	0	0	0	193.00
193.01	19302	0	0	0	0	0	193.01
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		0	0	207,960	11,113	82,827	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 152020

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

Worksheet B
Part II
Date/Time Prepared:
11/20/2012 4:54 pm

Cost Center Description		MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	PASTORAL CARE	OTHER GENERAL SERVICE (SPECIFY)	NONPHYSICIAN ANESTHETISTS	
		16.00	17.00	17.01	18.00	19.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
9.00	00901						9.00
10.00	01000						10.00
11.00	01100						11.00
12.00	01200						12.00
13.00	01300						13.00
14.00	01400						14.00
15.00	01500						15.00
16.00	01600	34,304					16.00
17.00	01700	0	18,827				17.00
17.01	01702	0	0	23,081			17.01
18.00	01850	0	0	0	0		18.00
19.00	01900	0	0	0	0	0	19.00
20.00	02000	0	0	0	0	0	20.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
23.00	02300	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	34,304	18,827	23,081	0	0	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	0	0	0	0	50.00
51.00	05100	0	0	0	0	0	51.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	0	0	0	0	0	54.00
55.00	05500	0	0	0	0	0	55.00
56.00	05600	0	0	0	0	0	56.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	0	0	0	0	0	60.00
60.01	06001	0	0	0	0	0	60.01
61.00	06100	0	0	0	0	0	61.00
62.00	06200	0	0	0	0	0	62.00
63.00	06300	0	0	0	0	0	63.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	0	0	0	0	0	65.00
66.00	06600	0	0	0	0	0	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	0	0	0	0	0	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
74.00	07400	0	0	0	0	0	74.00
75.00	07500	0	0	0	0	0	75.00
SPECIAL PURPOSE COST CENTERS							
118.00		34,304	18,827	23,081	0	0	118.00
NONREIMBURSABLE COST CENTERS							
193.00	19300	0	0	0	0	0	193.00
193.01	19302	0	0	0	0	0	193.01
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		34,304	18,827	23,081	0	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 152020

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

Worksheet B
Part II
Date/Time Prepared:
11/20/2012 4:54 pm

Cost Center Description	INTERNS & RESIDENTS				PARAMED ED PRGM	Subtotal
	NURSING SCHOOL	SERVICES-SALAR Y & FRINGES	SERVICES-OTHER PRGM COSTS			
	20.00	21.00	22.00	23.00		
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS					4.00
5.00 00500	ADMINISTRATIVE & GENERAL					5.00
6.00 00600	MAINTENANCE & REPAIRS					6.00
7.00 00700	OPERATION OF PLANT					7.00
9.00 00901	HOUSEKEEPING					9.00
10.00 01000	DIETARY					10.00
11.00 01100	CAFETERIA					11.00
12.00 01200	MAINTENANCE OF PERSONNEL					12.00
13.00 01300	NURSING ADMINISTRATION					13.00
14.00 01400	CENTRAL SERVICES & SUPPLY					14.00
15.00 01500	PHARMACY					15.00
16.00 01600	MEDICAL RECORDS & LIBRARY					16.00
17.00 01700	SOCIAL SERVICE					17.00
17.01 01702	PASTORAL CARE					17.01
18.00 01850	OTHER GENERAL SERVICE (SPECIFY)					18.00
19.00 01900	NONPHYSICIAN ANESTHETISTS					19.00
20.00 02000	NURSING SCHOOL	0				20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD		0			21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD			0		22.00
23.00 02300	PARAMED ED PRGM-(SPECIFY)				0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS					2,285,110
ANCELLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM					12,092
51.00 05100	RECOVERY ROOM					0
52.00 05200	DELIVERY ROOM & LABOR ROOM					0
53.00 05300	ANESTHESIOLOGY					0
54.00 05400	RADIOLOGY-DIAGNOSTIC					41,102
55.00 05500	RADIOLOGY-THERAPEUTIC					0
56.00 05600	RADIOISOTOPE					0
57.00 05700	CT SCAN					11,012
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)					0
59.00 05900	CARDIAC CATHETERIZATION					0
60.00 06000	LABORATORY					10,208
60.01 06001	BLOOD LABORATORY					0
61.00 06100	PBP CLINICAL LAB SERVICES-PRGM ONLY					0
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS					0
63.00 06300	BLOOD STORING, PROCESSING & TRANS.					230
64.00 06400	INTRAVENOUS THERAPY					0
65.00 06500	RESPIRATORY THERAPY					75,786
66.00 06600	PHYSICAL THERAPY					32,502
67.00 06700	OCCUPATIONAL THERAPY					28,848
68.00 06800	SPEECH PATHOLOGY					24,888
69.00 06900	ELECTROCARDIOLOGY					440
70.00 07000	ELECTROENCEPHALOGRAPHY					3
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS					0
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS					0
73.00 07300	DRUGS CHARGED TO PATIENTS					82,827
74.00 07400	RENAL DIALYSIS					1,264
75.00 07500	ASC (NON-DISTINCT PART)					0
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	0	0	0	2,606,312
NONREIMBURSABLE COST CENTERS						
193.00 19300	NONPAID WORKERS					0
193.01 19302	MARKETING					1,034
200.00	Cross Foot Adjustments	0	0	0	0	0
201.00	Negative Cost Centers	0	0	0	0	0
202.00	TOTAL (sum lines 118-201)	0	0	0	0	2,607,346

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 152020

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

Worksheet B
Part II
Date/Time Prepared:
11/20/2012 4:54 pm

Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
6.00	00600	MAINTENANCE & REPAIRS		6.00
7.00	00700	OPERATION OF PLANT		7.00
9.00	00901	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
12.00	01200	MAINTENANCE OF PERSONNEL		12.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE		17.00
17.01	01702	PASTORAL CARE		17.01
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)		18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS		19.00
20.00	02000	NURSING SCHOOL		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)		23.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	2,285,110
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	12,092
51.00	05100	RECOVERY ROOM	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0
53.00	05300	ANESTHESIOLOGY	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	41,102
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0
56.00	05600	RADIOISOTOPE	0	0
57.00	05700	CT SCAN	0	11,012
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0
60.00	06000	LABORATORY	0	10,208
60.01	06001	BLOOD LABORATORY	0	0
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	230
64.00	06400	INTRAVENOUS THERAPY	0	0
65.00	06500	RESPIRATORY THERAPY	0	75,786
66.00	06600	PHYSICAL THERAPY	0	32,502
67.00	06700	OCCUPATIONAL THERAPY	0	28,848
68.00	06800	SPEECH PATHOLOGY	0	24,888
69.00	06900	ELECTROCARDIOLOGY	0	440
70.00	07000	ELECTROENCEPHALOGRAPHY	0	3
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	82,827
74.00	07400	RENAL DIALYSIS	0	1,264
75.00	07500	ASC (NON-DISTINCT PART)	0	0
SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	2,606,312
NONREIMBURSABLE COST CENTERS				
193.00	19300	NONPAID WORKERS	0	0
193.01	19302	MARKETING	0	1,034
200.00		Cross Foot Adjustments	0	0
201.00		Negative Cost Centers	0	0
202.00		TOTAL (sum lines 118-201)	0	2,607,346

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				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	46,445				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		46,445			2.00
4.00 00400	EMPLOYEE BENEFITS	0	0	18,349,367		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	1,128	1,128	2,767,405	-6,475,418	33,584,297
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	0
7.00 00700	OPERATION OF PLANT	3,693	3,693	392,377	0	1,610,455
9.00 00901	HOUSEKEEPING	969	969	154,964	0	580,477
10.00 01000	DIETARY	2,013	2,013	232,111	0	763,962
11.00 01100	CAFETERIA	0	0	0	0	0
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00 01300	NURSING ADMINISTRATION	3,276	3,276	919,724	0	1,393,672
14.00 01400	CENTRAL SERVICES & SUPPLY	177	177	0	0	9,936
15.00 01500	PHARMACY	1,182	1,182	1,516,563	0	4,635,809
16.00 01600	MEDICAL RECORDS & LIBRARY	537	537	122,379	0	342,048
17.00 01700	SOCIAL SERVICE	295	295	123,387	0	178,867
17.01 01702	PASTORAL CARE	364	364	90,672	0	141,013
18.00 01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
20.00 02000	NURSING SCHOOL	0	0	0	0	0
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0
23.00 02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	30,372	30,372	8,130,845	0	14,358,035
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	179	179	145,810	0	462,233
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	640	640	172,804	0	524,414
55.00 05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0
56.00 05600	RADIOISOTOPE	0	0	0	0	0
57.00 05700	CT SCAN	170	170	134,325	0	188,866
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	139	139	0	0	793,628
60.01 06001	BLOOD LABORATORY	0	0	0	0	0
61.00 06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	121,787
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00 06500	RESPIRATORY THERAPY	252	252	2,310,125	0	4,589,096
66.00 06600	PHYSICAL THERAPY	353	353	478,513	0	743,022
67.00 06700	OCCUPATIONAL THERAPY	353	353	326,590	0	471,981
68.00 06800	SPEECH PATHOLOGY	353	353	154,112	0	221,862
69.00 06900	ELECTROCARDIOLOGY	0	0	175,633	0	233,198
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	1,028	0	1,590
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
74.00 07400	RENAL DIALYSIS	0	0	0	0	670,307
75.00 07500	ASC (NON-DISTINCT PART)	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	46,445	46,445	18,349,367	-6,475,418	33,036,258
NONREIMBURSABLE COST CENTERS						
193.00 19300	NONPAID WORKERS	0	0	0	0	0
193.01 19302	MARKETING	0	0	0	0	548,039
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per wkst. B, Part I)	1,597,880	1,009,466	5,664,005		6,475,418
203.00	Unit cost multiplier (wkst. B, Part I)	34.403703	21.734654	0.308676		0.192811
204.00	Cost to be allocated (per wkst. B, Part II)			0		63,324
205.00	Unit cost multiplier (wkst. B, Part II)			0.000000		0.001886

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 152020

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

Worksheet B-1

Date/Time Prepared:
11/20/2012 4:54 pm

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	HOUSEKEEPING (SQUARE FEET)	DIETARY (TOTAL PATIENT DAYS)	CAFETERIA (MEALS SERVED)	
		6.00	7.00	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
6.00	00600	MAINTENANCE & REPAIRS	0				6.00
7.00	00700	OPERATION OF PLANT	0	41,624			7.00
9.00	00901	HOUSEKEEPING	0	969	40,655		9.00
10.00	01000	DIETARY	0	2,013	2,013	22,415	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	3,276	3,276	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	177	177	0	14.00
15.00	01500	PHARMACY	0	1,182	1,182	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	537	537	0	16.00
17.00	01700	SOCIAL SERVICE	0	295	295	0	17.00
17.01	01702	PASTORAL CARE	0	364	364	0	17.01
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	30,372	30,372	22,415	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	179	179	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	640	640	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	170	170	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	139	139	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	252	252	0	65.00
66.00	06600	PHYSICAL THERAPY	0	353	353	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	353	353	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	353	353	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	41,624	40,655	22,415	118.00
NONREIMBURSABLE COST CENTERS							
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
193.01	19302	MARKETING	0	0	0	0	193.01
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	1,920,968	737,119	1,040,661	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	46.150490	18.131079	46.426991	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	210,356	60,390	127,611	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	5.053719	1.485426	5.693107	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN:152020

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

Worksheet B-1

Date/Time Prepared:
11/20/2012 4:54 pm

Cost Center Description		MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TOTAL PATIENT DAYS)	
		12.00	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
6.00	00600						6.00
7.00	00700						7.00
9.00	00901						9.00
10.00	01000						10.00
11.00	01100						11.00
12.00	01200	0					12.00
13.00	01300	0	382,052				13.00
14.00	01400	0	0	100			14.00
15.00	01500	0	0	0	100		15.00
16.00	01600	0	0	0	0	22,415	16.00
17.00	01700	0	0	0	0	0	17.00
17.01	01702	0	0	0	0	0	17.01
18.00	01850	0	0	0	0	0	18.00
19.00	01900	0	0	0	0	0	19.00
20.00	02000	0	0	0	0	0	20.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
23.00	02300	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	0	276,641	0	0	22,415	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	0	0	0	0	50.00
51.00	05100	0	0	0	0	0	51.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	0	0	0	0	0	54.00
55.00	05500	0	0	0	0	0	55.00
56.00	05600	0	0	0	0	0	56.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	0	0	0	0	0	60.00
60.01	06001	0	0	0	0	0	60.01
61.00	06100	0	0	0	0	0	61.00
62.00	06200	0	0	0	0	0	62.00
63.00	06300	0	0	0	0	0	63.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	0	73,896	100	0	0	65.00
66.00	06600	0	16,491	0	0	0	66.00
67.00	06700	0	10,716	0	0	0	67.00
68.00	06800	0	4,308	0	0	0	68.00
69.00	06900	0	0	0	0	0	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	100	0	73.00
74.00	07400	0	0	0	0	0	74.00
75.00	07500	0	0	0	0	0	75.00
SPECIAL PURPOSE COST CENTERS							
118.00		0	382,052	100	100	22,415	118.00
NONREIMBURSABLE COST CENTERS							
193.00	19300	0	0	0	0	0	193.00
193.01	19302	0	0	0	0	0	193.01
200.00							200.00
201.00							201.00
202.00		0	1,872,973	23,230	5,605,625	442,518	202.00
203.00		0.000000	4.902403	232.300000	56,056.250000	19.742048	203.00
204.00		0	207,960	11,113	82,827	34,304	204.00
205.00		0.000000	0.544324	111.130000	828.270000	1.530404	205.00

Cost Center Description	SOCIAL SERVICE	PASTORAL CARE	OTHER GENERAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
	(TOTAL PATIENT DAYS)	(TOTAL PATIENT DAYS)	(SPECIFY) (TIME SPENT)	(ASSIGNED TIME)	(ASSIGNED TIME)	
	17.00	17.01	18.00	19.00	20.00	
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS						4.00
5.00 00500 ADMINISTRATIVE & GENERAL						5.00
6.00 00600 MAINTENANCE & REPAIRS						6.00
7.00 00700 OPERATION OF PLANT						7.00
9.00 00901 HOUSEKEEPING						9.00
10.00 01000 DIETARY						10.00
11.00 01100 CAFETERIA						11.00
12.00 01200 MAINTENANCE OF PERSONNEL						12.00
13.00 01300 NURSING ADMINISTRATION						13.00
14.00 01400 CENTRAL SERVICES & SUPPLY						14.00
15.00 01500 PHARMACY						15.00
16.00 01600 MEDICAL RECORDS & LIBRARY						16.00
17.00 01700 SOCIAL SERVICE	22,415					17.00
17.01 01702 PASTORAL CARE	0	22,415				17.01
18.00 01850 OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0	18.00
19.00 01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00 02000 NURSING SCHOOL	0	0	0	0	0	20.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00 02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	22,415	22,415	0	0	0	30.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00 05600 RADIOISOTOPE	0	0	0	0	0	56.00
57.00 05700 CT SCAN	0	0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000 LABORATORY	0	0	0	0	0	60.00
60.01 06001 BLOOD LABORATORY	0	0	0	0	0	60.01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1-117)	22,415	22,415	0	0	0	118.00
NONREIMBURSABLE COST CENTERS						
193.00 19300 NONPAID WORKERS	0	0	0	0	0	193.00
193.01 19302 MARKETING	0	0	0	0	0	193.01
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	232,318	191,601	0	0	0	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	10.364399	8.547892	0.000000	0.000000	0.000000	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	18,827	23,081	0	0	0	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)	0.839929	1.029712	0.000000	0.000000	0.000000	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN:152020

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

Worksheet B-1
Date/Time Prepared:
11/20/2012 4:54 pm

Cost Center Description	INTERNS & RESIDENTS			PARAMED ED PRGM (ASSIGNED TIME)	
	SERVICES-SALARY & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)			
	21.00	22.00	23.00		
GENERAL SERVICE COST CENTERS					
1.00 00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00 00400	EMPLOYEE BENEFITS				4.00
5.00 00500	ADMINISTRATIVE & GENERAL				5.00
6.00 00600	MAINTENANCE & REPAIRS				6.00
7.00 00700	OPERATION OF PLANT				7.00
9.00 00901	HOUSEKEEPING				9.00
10.00 01000	DIETARY				10.00
11.00 01100	CAFETERIA				11.00
12.00 01200	MAINTENANCE OF PERSONNEL				12.00
13.00 01300	NURSING ADMINISTRATION				13.00
14.00 01400	CENTRAL SERVICES & SUPPLY				14.00
15.00 01500	PHARMACY				15.00
16.00 01600	MEDICAL RECORDS & LIBRARY				16.00
17.00 01700	SOCIAL SERVICE				17.00
17.01 01702	PASTORAL CARE				17.01
18.00 01850	OTHER GENERAL SERVICE (SPECIFY)				18.00
19.00 01900	NONPHYSICIAN ANESTHETISTS				19.00
20.00 02000	NURSING SCHOOL				20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0			21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD		0		22.00
23.00 02300	PARAMED ED PRGM-(SPECIFY)			0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 03000	ADULTS & PEDIATRICS	0	0	0	30.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000	OPERATING ROOM	0	0	0	50.00
51.00 05100	RECOVERY ROOM	0	0	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00 05300	ANESTHESIOLOGY	0	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	0	0	0	55.00
56.00 05600	RADIOISOTOPE	0	0	0	56.00
57.00 05700	CT SCAN	0	0	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	59.00
60.00 06000	LABORATORY	0	0	0	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	60.01
61.00 06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	61.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	62.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	63.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	0	0	0	65.00
66.00 06600	PHYSICAL THERAPY	0	0	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	0	0	0	74.00
75.00 07500	ASC (NON-DISTINCT PART)	0	0	0	75.00
SPECIAL PURPOSE COST CENTERS					
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	0	0	118.00
NONREIMBURSABLE COST CENTERS					
193.00 19300	NONPAID WORKERS	0	0	0	193.00
193.01 19302	MARKETING	0	0	0	193.01
200.00	Cross Foot Adjustments				200.00
201.00	Negative Cost Centers				201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	0	0	0	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.000000	0.000000	0.000000	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	0	0	0	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000000	0.000000	0.000000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 152020

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

Worksheet C
Part I
Date/Time Prepared:
11/20/2012 4:54 pm

		Title XVIII		Hospital		PPS	
Cost Center Description	Total Cost (from wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE Disallowance	Total Costs		
	1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	22,342,082	22,342,082	0	22,342,082	30.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	562,863	562,863	0	562,863	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	666,667	666,667	0	666,667	54.00	
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00	
56.00	05600 RADIOISOTOPE	0	0	0	0	56.00	
57.00	05700 CT SCAN	236,209	236,209	0	236,209	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	955,583	955,583	0	955,583	60.00	
60.01	06001 BLOOD LABORATORY	0	0	0	0	60.01	
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	61.00	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	62.00	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	145,269	145,269	0	145,269	63.00	
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	64.00	
65.00	06500 RESPIRATORY THERAPY	5,875,621	5,875,621	0	5,875,621	65.00	
66.00	06600 PHYSICAL THERAPY	989,822	989,822	0	989,822	66.00	
67.00	06700 OCCUPATIONAL THERAPY	638,209	638,209	0	638,209	67.00	
68.00	06800 SPEECH PATHOLOGY	308,450	308,450	0	308,450	68.00	
69.00	06900 ELECTROCARDIOLOGY	278,161	278,161	0	278,161	69.00	
70.00	07000 ELECTROENCEPHALOGRAPHY	1,897	1,897	0	1,897	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	5,605,625	5,605,625	0	5,605,625	73.00	
74.00	07400 RENAL DIALYSIS	799,550	799,550	0	799,550	74.00	
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0	0	75.00	
200.00	Subtotal (see instructions)	39,406,008	39,406,008	0	39,406,008	200.00	
201.00	Less Observation Beds	0	0	0	0	201.00	
202.00	Total (see instructions)	39,406,008	39,406,008	0	39,406,008	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 152020

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

Worksheet C
Part I
Date/Time Prepared:
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		Title XVIII			Hospital	PPS	
Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	39,446,306		39,446,306		30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,142,845	0	2,142,845	0.262671	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,097,560	21,173	2,118,733	0.314654	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	1,219,435	6,730	1,226,165	0.192640	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	11,218,080	1,553	11,219,633	0.085171	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0.000000	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0.000000	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	511,681	0	511,681	0.283905	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	26,861,437	217,806	27,079,243	0.216979	65.00
66.00	06600	PHYSICAL THERAPY	2,822,907	0	2,822,907	0.350639	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,646,317	0	2,646,317	0.241169	67.00
68.00	06800	SPEECH PATHOLOGY	783,255	0	783,255	0.393805	68.00
69.00	06900	ELECTROCARDIOLOGY	754,162	5,966	760,128	0.365940	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	29,787	0	29,787	0.063686	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	17,854,989	6,087	17,861,076	0.313846	73.00
74.00	07400	RENAL DIALYSIS	1,611,272	0	1,611,272	0.496223	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	75.00
200.00		Subtotal (see instructions)	110,000,033	259,315	110,259,348		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	110,000,033	259,315	110,259,348		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 152020

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

Worksheet C
Part I
Date/Time Prepared:
11/20/2012 4:54 pm

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.262671			50.00
51.00	05100 RECOVERY ROOM	0.000000			51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	05300 ANESTHESIOLOGY	0.000000			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.314654			54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000			55.00
56.00	05600 RADIOISOTOPE	0.000000			56.00
57.00	05700 CT SCAN	0.192640			57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000			58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000			59.00
60.00	06000 LABORATORY	0.085171			60.00
60.01	06001 BLOOD LABORATORY	0.000000			60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000			61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000			62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.283905			63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000			64.00
65.00	06500 RESPIRATORY THERAPY	0.216979			65.00
66.00	06600 PHYSICAL THERAPY	0.350639			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.241169			67.00
68.00	06800 SPEECH PATHOLOGY	0.393805			68.00
69.00	06900 ELECTROCARDIOLOGY	0.365940			69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.063686			70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.313846			73.00
74.00	07400 RENAL DIALYSIS	0.496223			74.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000			75.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 152020

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

Worksheet C
Part I
Date/Time Prepared:
11/20/2012 4:54 pm

Cost Center Description	Total Cost (from wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	22,342,082		22,342,082	0	0	30.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	562,863		562,863	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	666,667		666,667	0	0	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0		0	0	0	55.00
56.00 05600 RADIOISOTOPE	0		0	0	0	56.00
57.00 05700 CT SCAN	236,209		236,209	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	955,583		955,583	0	0	60.00
60.01 06001 BLOOD LABORATORY	0		0	0	0	60.01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0		0	0	0	61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0		0	0	0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	145,269		145,269	0	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	5,875,621	0	5,875,621	0	0	65.00
66.00 06600 PHYSICAL THERAPY	989,822	0	989,822	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	638,209	0	638,209	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	308,450	0	308,450	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	278,161		278,161	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	1,897		1,897	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	5,605,625		5,605,625	0	0	73.00
74.00 07400 RENAL DIALYSIS	799,550		799,550	0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0		0	0	0	75.00
200.00 Subtotal (see instructions)	39,406,008	0	39,406,008	0	0	200.00
201.00 Less Observation Beds	0		0	0	0	201.00
202.00 Total (see instructions)	39,406,008	0	39,406,008	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 152020

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

Worksheet C
Part I
Date/Time Prepared:
11/20/2012 4:54 pm

Cost Center Description	Title XIX			Hospital	Cost	TEFRA Inpatient Ratio	
	Charges			Cost or Other Ratio	10.00		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00	9.00			
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	39,446,306		39,446,306		30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,142,845	0	2,142,845	0.262671	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,097,560	21,173	2,118,733	0.314654	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	1,219,435	6,730	1,226,165	0.192640	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	11,218,080	1,553	11,219,633	0.085171	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0.000000	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0.000000	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	511,681	0	511,681	0.283905	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	26,861,437	217,806	27,079,243	0.216979	65.00
66.00	06600	PHYSICAL THERAPY	2,822,907	0	2,822,907	0.350639	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,646,317	0	2,646,317	0.241169	67.00
68.00	06800	SPEECH PATHOLOGY	783,255	0	783,255	0.393805	68.00
69.00	06900	ELECTROCARDIOLOGY	754,162	5,966	760,128	0.365940	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	29,787	0	29,787	0.063686	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	17,854,989	6,087	17,861,076	0.313846	73.00
74.00	07400	RENAL DIALYSIS	1,611,272	0	1,611,272	0.496223	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	75.00
200.00		Subtotal (see instructions)	110,000,033	259,315	110,259,348		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	110,000,033	259,315	110,259,348		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 152020

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

Worksheet C
Part I
Date/Time Prepared:
11/20/2012 4:54 pm

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000			50.00
51.00	05100 RECOVERY ROOM	0.000000			51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	05300 ANESTHESIOLOGY	0.000000			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000			55.00
56.00	05600 RADIOISOTOPE	0.000000			56.00
57.00	05700 CT SCAN	0.000000			57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000			58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000			59.00
60.00	06000 LABORATORY	0.000000			60.00
60.01	06001 BLOOD LABORATORY	0.000000			60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000			61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000			62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000			63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000			64.00
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800 SPEECH PATHOLOGY	0.000000			68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
74.00	07400 RENAL DIALYSIS	0.000000			74.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000			75.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 152020

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

Worksheet D
Part I
Date/Time Prepared:
11/20/2012 4:54 pm

Cost Center Description		Title XVIII			Hospital	PPS		
		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	2,285,110	0	2,285,110	22,415	101.95	30.00
200.00		Total (lines 30-199)	2,285,110		2,285,110	22,415		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 152020

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

Worksheet D
Part I
Date/Time Prepared:
11/20/2012 4:54 pm

Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	14,666	1,495,199
200.00		Total (lines 30-199)	14,666	1,495,199

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 152020	Period: From 07/01/2011 To 06/30/2012	Worksheet D Part II Date/Time Prepared: 11/20/2012 4:54 pm
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Cost Center Description	Title XVIII			Hospital	PPS			
	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	12,092	2,142,845	0.005643	2,031,983	11,466	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	41,102	2,118,733	0.019399	1,233,048	23,920	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0.000000	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	11,012	1,226,165	0.008981	724,232	6,504	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	10,208	11,219,633	0.000910	7,448,613	6,778	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0.000000	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.000000	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	230	511,681	0.000449	361,611	162	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	75,786	27,079,243	0.002799	18,768,485	52,533	65.00
66.00	06600	PHYSICAL THERAPY	32,502	2,822,907	0.011514	1,459,104	16,800	66.00
67.00	06700	OCCUPATIONAL THERAPY	28,848	2,646,317	0.010901	1,500,202	16,354	67.00
68.00	06800	SPEECH PATHOLOGY	24,888	783,255	0.031775	486,980	15,474	68.00
69.00	06900	ELECTROCARDIOLOGY	440	760,128	0.000579	146,026	85	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	3	29,787	0.000101	17,099	2	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	82,827	17,861,076	0.004637	10,924,656	50,658	73.00
74.00	07400	RENAL DIALYSIS	1,264	1,611,272	0.000784	1,027,737	806	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
200.00		Total (lines 50-199)	321,202	70,813,042		46,129,776	201,542	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 152020		Period: From 07/01/2011 To 06/30/2012		Worksheet D Part III Date/Time Prepared: 11/20/2012 4:54 pm	
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)
			1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0 30.00
200.00		Total (lines 30-199)	0	0	0	0	0 200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 152020		Period: From 07/01/2011 To 06/30/2012		Worksheet D Part III Date/Time Prepared: 11/20/2012 4:54 pm	
Cost Center Description		Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Hospital Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PPS PSA Adj. Nursing School	
		6.00	7.00	8.00	9.00	11.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	22,415	0.00	14,666	0	0 30.00
200.00		Total (lines 30-199)	22,415		14,666	0	0 200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 152020		Period: From 07/01/2011 To 06/30/2012		Worksheet D Part III Date/Time Prepared: 11/20/2012 4:54 pm	
Cost Center Description			PSA Adj. Allied Health Cost 12.00	PSA Adj. All Other Medical Education Cost 13.00	Title XVIII	Hospital	PPS
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0			30.00
200.00		Total (lines 30-199)	0	0			200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 152020

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

Worksheet D
Part IV
Date/Time Prepared:
11/20/2012 4:54 pm

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 152020

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

Worksheet D
Part IV
Date/Time Prepared:
11/20/2012 4:54 pm

Cost Center Description		Title XVIII			Hospital		PPS	
		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	2,142,845	0.000000	0.000000	2,031,983	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,118,733	0.000000	0.000000	1,233,048	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0.000000	0.000000	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
57.00	05700	CT SCAN	0	1,226,165	0.000000	0.000000	724,232	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	11,219,633	0.000000	0.000000	7,448,613	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0.000000	0.000000	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.000000	0.000000	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	511,681	0.000000	0.000000	361,611	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	27,079,243	0.000000	0.000000	18,768,485	65.00
66.00	06600	PHYSICAL THERAPY	0	2,822,907	0.000000	0.000000	1,459,104	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,646,317	0.000000	0.000000	1,500,202	67.00
68.00	06800	SPEECH PATHOLOGY	0	783,255	0.000000	0.000000	486,980	68.00
69.00	06900	ELECTROCARDIOLOGY	0	760,128	0.000000	0.000000	146,026	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	29,787	0.000000	0.000000	17,099	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	17,861,076	0.000000	0.000000	10,924,656	73.00
74.00	07400	RENAL DIALYSIS	0	1,611,272	0.000000	0.000000	1,027,737	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0.000000	0	75.00
200.00		Total (lines 50-199)	0	70,813,042			46,129,776	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 152020

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

Worksheet D
Part IV
Date/Time Prepared:
11/20/2012 4:54 pm

Cost Center Description	Title XVIII			Hospital	PPS		
	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School		
	11.00	12.00	13.00	21.00	22.00		
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	21,173	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	6,730	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	1,553	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	217,806	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	5,966	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	6,087	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
200.00		Total (lines 50-199)	0	259,315	0	0	200.00

APPORIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 152020

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

Worksheet D
Part IV
Date/Time Prepared:
11/20/2012 4:54 pm

Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	
		23.00	24.00	
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	55.00
56.00	05600 RADIOISOTOPE	0	0	56.00
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000 LABORATORY	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	75.00
200.00	Total (lines 50-199)	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 152020	Period: From 07/01/2011 To 06/30/2012	Worksheet D Part V Date/Time Prepared: 11/20/2012 4:54 pm
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Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			PPS	PPS	
		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
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.262671	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.314654	21,173	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	56.00
57.00	05700	CT SCAN	0.192640	6,730	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	59.00
60.00	06000	LABORATORY	0.085171	1,553	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.283905	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.216979	217,806	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.350639	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.241169	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.393805	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.365940	5,966	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.063686	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	0.313846	6,087	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.496223	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	75.00
200.00		Subtotal (see instructions)		259,315	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00		Net Charges (line 200 +/- line 201)		259,315	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 152020

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

Worksheet D
Part V
Date/Time Prepared:
11/20/2012 4:54 pm

		Title XVIII			Hospital	PPS
Cost Center Description		Costs				
		PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)		
		5.00	6.00	7.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,662	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	56.00
57.00	05700	CT SCAN	1,296	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000	LABORATORY	132	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	47,259	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,183	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,910	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	75.00
200.00		Subtotal (see instructions)	59,442	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges		0	0	201.00
202.00		Net Charges (line 200 +/- line 201)	59,442	0	0	202.00

APPORIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 152020

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

Worksheet D
Part I
Date/Time Prepared:
11/20/2012 4:54 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	2,285,110	0	2,285,110	22,415	101.95	30.00
200.00		Total (lines 30-199)	2,285,110		2,285,110	22,415		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 152020

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

Worksheet D
Part I
Date/Time Prepared:
11/20/2012 4:54 pm

Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	Cost
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS	284	28,954	30.00
200.00	Total (lines 30-199)	284	28,954	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 152020

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

Worksheet D
Part II
Date/Time Prepared:
11/20/2012 4:54 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	12,092	2,142,845	0.005643	22,798	129	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	41,102	2,118,733	0.019399	26,592	516	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0.000000	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	11,012	1,226,165	0.008981	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	10,208	11,219,633	0.000910	127,479	116	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0.000000	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.000000	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	230	511,681	0.000449	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	75,786	27,079,243	0.002799	317,315	888	65.00
66.00	06600	PHYSICAL THERAPY	32,502	2,822,907	0.011514	40,619	468	66.00
67.00	06700	OCCUPATIONAL THERAPY	28,848	2,646,317	0.010901	47,571	519	67.00
68.00	06800	SPEECH PATHOLOGY	24,888	783,255	0.031775	8,531	271	68.00
69.00	06900	ELECTROCARDIOLOGY	440	760,128	0.000579	4,730	3	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	3	29,787	0.000101	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	82,827	17,861,076	0.004637	220,268	1,021	73.00
74.00	07400	RENAL DIALYSIS	1,264	1,611,272	0.000784	23,202	18	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
200.00		Total (lines 50-199)	321,202	70,813,042		839,105	3,949	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 152020

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

Worksheet D
Part III
Date/Time Prepared:
11/20/2012 4:54 pm

Cost Center Description	Title XIX			Hospital	Total Costs (sum of cols. 1 through 3, minus col. 4)	
	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)		
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	0	0	0	0	0	30.00
200.00 Total (lines 30-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 152020

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

Worksheet D
Part III
Date/Time Prepared:
11/20/2012 4:54 pm

Cost Center Description	Total Patient Days	Title XIX			Hospital Cost	
		Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. Nursing School	
	6.00	7.00	8.00	9.00	11.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	22,415	0.00	284	0	0	30.00
200.00 Total (lines 30-199)	22,415		284	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 152020		Period: From 07/01/2011 To 06/30/2012		Worksheet D Part III Date/Time Prepared: 11/20/2012 4:54 pm	
Cost Center Description			PSA Adj. Allied Health Cost	PSA Adj. All Other Medical Education Cost	Title XIX	Hospital	Cost
			12.00	13.00			
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0			30.00
200.00		Total (lines 30-199)	0	0			200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 152020

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

Worksheet D
Part IV
Date/Time Prepared:
11/20/2012 4:54 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
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 152020

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

Worksheet D
Part IV
Date/Time Prepared:
11/20/2012 4:54 pm

Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital		Cost		
				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	2,142,845	0.000000	0.000000	22,798	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,118,733	0.000000	0.000000	26,592	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0.000000	0.000000	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
57.00	05700	CT SCAN	0	1,226,165	0.000000	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	11,219,633	0.000000	0.000000	127,479	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0.000000	0.000000	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.000000	0.000000	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	511,681	0.000000	0.000000	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	27,079,243	0.000000	0.000000	317,315	65.00
66.00	06600	PHYSICAL THERAPY	0	2,822,907	0.000000	0.000000	40,619	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,646,317	0.000000	0.000000	47,571	67.00
68.00	06800	SPEECH PATHOLOGY	0	783,255	0.000000	0.000000	8,531	68.00
69.00	06900	ELECTROCARDIOLOGY	0	760,128	0.000000	0.000000	4,730	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	29,787	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	17,861,076	0.000000	0.000000	220,268	73.00
74.00	07400	RENAL DIALYSIS	0	1,611,272	0.000000	0.000000	23,202	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0.000000	0	75.00
200.00		Total (lines 50-199)	0	70,813,042			839,105	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 152020

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

Worksheet D
Part IV
Date/Time Prepared:
11/20/2012 4:54 pm

Cost Center Description	Title XIX			Hospital		
	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
	11.00	12.00	13.00	21.00	22.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00 05600 RADIOISOTOPE	0	0	0	0	0	56.00
57.00 05700 CT SCAN	0	0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000 LABORATORY	0	0	0	0	0	60.00
60.01 06001 BLOOD LABORATORY	0	0	0	0	0	60.01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
200.00 Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 152020

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

Worksheet D
Part IV
Date/Time Prepared:
11/20/2012 4:54 pm

Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	Cost
		23.00	24.00	
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	55.00
56.00	05600 RADIOISOTOPE	0	0	56.00
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000 LABORATORY	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	75.00
200.00	Total (lines 50-199)	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 152020	Period: From 07/01/2011 To 06/30/2012	Worksheet D-1 Date/Time Prepared: 11/20/2012 4:54 pm
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		22,415	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		22,415	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)		22,415	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		14,666	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		22,342,082	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		22,342,082	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		39,446,306	28.00
29.00	Private room charges (excluding swing-bed charges)		39,446,306	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.566392	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)		0.00	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)		22,342,082	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)		996.75	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		14,618,336	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)		14,618,336	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 152020	Period: From 07/01/2011 To 06/30/2012	Worksheet D-1 Date/Time Prepared: 11/20/2012 4:54 pm		
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
Title XVIII		1.00	2.00	3.00	4.00	5.00
Hospital		PPS				
42.00	NURSERY (title V & XIX only)					42.00
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT					43.00
44.00	CORONARY CARE UNIT					44.00
45.00	BURN INTENSIVE CARE UNIT					45.00
46.00	SURGICAL INTENSIVE CARE UNIT					46.00
47.00	OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description						
48.00	Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					10,929,047 48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					25,547,383 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)					1,495,199 50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from wkst. D, sum of Parts II and IV)					201,542 51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					1,696,741 52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					23,850,642 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)					0 87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00 88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0 89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 152020

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

Worksheet D-1

Date/Time Prepared:
11/20/2012 4:54 pm

Cost Center Description	Cost	Title XVIII		Hospital	PPS	
		Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	2,285,110	22,342,082	0.102278	0	0	90.00
91.00 Nursing School cost	0	22,342,082	0.000000	0	0	91.00
92.00 Allied health cost	0	22,342,082	0.000000	0	0	92.00
93.00 All other Medical Education	0	22,342,082	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 152020	Period: From 07/01/2011 To 06/30/2012	Worksheet D-1 Date/Time Prepared: 11/20/2012 4:54 pm
Cost Center Description		Title XIX	Hospital	Cost
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		22,415	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		22,415	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)		22,415	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		284	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		22,342,082	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		22,342,082	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		39,446,306	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		39,446,306	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.566392	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)		1,759.82	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)		22,342,082	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)		996.75	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		283,077	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)		283,077	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 152020	Period: From 07/01/2011 To 06/30/2012	Worksheet D-1 Date/Time Prepared: 11/20/2012 4:54 pm		
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 + col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)					42.00
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT					43.00
44.00	CORONARY CARE UNIT					44.00
45.00	BURN INTENSIVE CARE UNIT					45.00
46.00	SURGICAL INTENSIVE CARE UNIT					46.00
47.00	OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description						
						1.00
48.00	Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					205,514
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					488,591
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from wkst. D, sum of Parts I and III)					0
51.00	Pass through costs applicable to Program inpatient ancillary services (from wkst. D, sum of Parts II and IV)					0
52.00	Total Program excludable cost (sum of lines 50 and 51)					0
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0
55.00	Target amount per discharge					0.00
56.00	Target amount (line 54 x line 55)					0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00	Bonus payment (see instructions)					0
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0
62.00	Relief payment (see instructions)					0
63.00	Allowable inpatient cost plus incentive payment (see instructions)					0
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)					70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00	Program routine service cost (line 9 x line 71)					72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from worksheet B, Part II, column 26, line 45)					75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00	Program capital-related costs (line 9 x line 76)					77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00	Inpatient routine service cost per diem limitation					81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00	Reasonable inpatient routine service costs (see instructions)					83.00
84.00	Program inpatient ancillary services (see instructions)					84.00
85.00	utilization review - physician compensation (see instructions)					85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)					0
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 152020

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

Worksheet D-1

Date/Time Prepared:
11/20/2012 4:54 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	90.00
91.00	Nursing School cost	0	0	0.000000	0	91.00
92.00	Allied health cost	0	0	0.000000	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 152020	Period: From 07/01/2011 To 06/30/2012	Worksheet D-3	
Date/Time Prepared: 11/20/2012 4:54 pm		Title XVIII		Hospital	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		24,974,907		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.262671	2,031,983	533,743	50.00
51.00	05100 RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.314654	1,233,048	387,983	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	55.00
56.00	05600 RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700 CT SCAN	0.192640	724,232	139,516	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000 LABORATORY	0.085171	7,448,613	634,406	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	0	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.283905	361,611	102,663	63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.216979	18,768,485	4,072,367	65.00
66.00	06600 PHYSICAL THERAPY	0.350639	1,459,104	511,619	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.241169	1,500,202	361,802	67.00
68.00	06800 SPEECH PATHOLOGY	0.393805	486,980	191,775	68.00
69.00	06900 ELECTROCARDIOLOGY	0.365940	146,026	53,437	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.063686	17,099	1,089	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	0.313846	10,924,656	3,428,660	73.00
74.00	07400 RENAL DIALYSIS	0.496223	1,027,737	509,987	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
200.00	Total (sum of lines 50-94 and 96-98)		46,129,776	10,929,047	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)		46,129,776		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 152020	Period: From 07/01/2011 To 06/30/2012	Worksheet D-3 Date/Time Prepared: 11/20/2012 4:54 pm
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Cost Center Description		Ratio of Cost To Charges	Hospital Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		518,606		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.262671	22,798	5,988	50.00
51.00	05100 RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.314654	26,592	8,367	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	55.00
56.00	05600 RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700 CT SCAN	0.192640	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000 LABORATORY	0.085171	127,479	10,858	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	0	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.283905	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.216979	317,315	68,851	65.00
66.00	06600 PHYSICAL THERAPY	0.350639	40,619	14,243	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.241169	47,571	11,473	67.00
68.00	06800 SPEECH PATHOLOGY	0.393805	8,531	3,360	68.00
69.00	06900 ELECTROCARDIOLOGY	0.365940	4,730	1,731	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.063686	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	0.313846	220,268	69,130	73.00
74.00	07400 RENAL DIALYSIS	0.496223	23,202	11,513	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
200.00	Total (sum of lines 50-94 and 96-98)		839,105	205,514	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)		839,105	205,514	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 152020	Period: From 07/01/2011 To 06/30/2012	Worksheet E Part B Date/Time Prepared: 11/20/2012 4:54 pm
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPI (see instructions)		59,442	2.00
3.00	PPS payments		6,096	3.00
4.00	Outlier payment (see instructions)		8,903	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from worksheet D, Part IV, column 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from worksheet D-4, Part III, line 69, col. 4)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)		0	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		14,999	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		1,537	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)		13,462	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)		13,462	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		13,462	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from worksheet I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)		13,462	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)		13,462	40.00
41.00	Interim payments		13,462	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (line 40 minus the sum of lines 41, and 42)		0	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 152020

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

Worksheet E
Part B
Date/Time Prepared:
11/20/2012 4:54 pm

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 152020

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

Worksheet E-1
Part I
Date/Time Prepared:
11/20/2012 4:54 pm

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		23,771,730		13,462	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		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)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to wkst. E or wkst. E-3, line and column as appropriate)		23,771,730		13,462	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		275,949		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		24,047,679		13,462	7.00	
				Contractor Number		Date (Mo/Day/Yr)	
				0		1.00 2.00	
8.00	Name of Contractor						

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 152020	Period: From 07/01/2011 To 06/30/2012	Worksheet E-3 Part IV Date/Time Prepared: 11/20/2012 4:54 pm
		Title XVIII	Hospital	PPS
		1.00		
PART IV - MEDICARE PART A SERVICES - LTCH PPS				
1.00	Net Federal PPS Payments (see instructions)		21,989,072	1.00
2.00	Outlier Payments		3,609,174	2.00
3.00	Total PPS Payments (sum of lines 1 and 2)		25,598,246	3.00
4.00	Nursing and Allied Health Managed Care payments (see instructions)		0	4.00
5.00	Organ acquisition		0	5.00
6.00	Cost of teaching physicians		0	6.00
7.00	Subtotal (see instructions)		25,598,246	7.00
8.00	Primary payer payments		0	8.00
9.00	Subtotal (line 7 less line 8).		25,598,246	9.00
10.00	Deductibles		39,908	10.00
11.00	Subtotal (line 9 minus line 10)		25,558,338	11.00
12.00	Coinsurance		1,786,608	12.00
13.00	Subtotal (line 11 minus line 12)		23,771,730	13.00
14.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		394,213	14.00
15.00	Adjusted reimbursable bad debts (see instructions)		275,949	15.00
16.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		290,539	16.00
17.00	Subtotal (sum of lines 13 and 15)		24,047,679	17.00
18.00	Direct graduate medical education payments (from worksheet E-4, line 49)		0	18.00
19.00	Other pass through costs (see instructions)		0	19.00
20.00	Outlier payments reconciliation		0	20.00
21.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	21.00
21.99	Recovery of Accelerated Depreciation		0	21.99
22.00	Total amount payable to the provider (see instructions)		24,047,679	22.00
23.00	Interim payments		23,771,730	23.00
24.00	Tentative settlement (for contractor use only)		0	24.00
25.00	Balance due provider/program (line 22 minus the sum lines 23 and 24)		275,949	25.00
26.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		0	26.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part IV, line 2		0	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)		0	51.00
52.00	The rate used to calculate the Time Value of Money		0.00	52.00
53.00	Time Value of Money (see instructions)		0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 152020	Period: From 07/01/2011 To 06/30/2012	Worksheet E-3 Part VII Date/Time Prepared: 11/20/2012 4:54 pm
		Title XIX	Hospital	Cost
				1.00
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		488,591	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)		488,591	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)		488,591	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges		518,606	8.00
9.00	Ancillary service charges		839,105	9.00
10.00	Organ acquisition charges, net of revenue		0	10.00
11.00	Incentive from target amount computation		0	11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		1,357,711	12.00
CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	15.00
16.00	Total customary charges (see instructions)		1,357,711	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		869,120	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)		488,591	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.		488,591	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)		488,591	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)		488,591	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	37.00
38.00	Subtotal (line 36 ± line 37)		488,591	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)		488,591	40.00
41.00	Interim payments		488,591	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: 152020

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

Worksheet G

Date/Time Prepared:
11/20/2012 4:54 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	1,664,091	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	15,251,189	0	0	0	4.00
5.00 Other receivable	264,673	0	0	0	5.00
6.00 Allowances for uncollectible notes and accounts receivable	-6,056,698	0	0	0	6.00
7.00 Inventory	406,968	0	0	0	7.00
8.00 Prepaid expenses	12,187	0	0	0	8.00
9.00 Other current assets	292,407	0	0	0	9.00
10.00 Due from other funds	0	0	0	0	10.00
11.00 Total current assets (sum of lines 1-10)	11,834,817	0	0	0	11.00
FIXED ASSETS					
12.00 Land	847,629	0	0	0	12.00
13.00 Land improvements	3,157	0	0	0	13.00
14.00 Accumulated depreciation	-1,289	0	0	0	14.00
15.00 Buildings	15,968,323	0	0	0	15.00
16.00 Accumulated depreciation	-4,281,981	0	0	0	16.00
17.00 Leasehold improvements	0	0	0	0	17.00
18.00 Accumulated depreciation	0	0	0	0	18.00
19.00 Fixed equipment	0	0	0	0	19.00
20.00 Accumulated depreciation	0	0	0	0	20.00
21.00 Automobiles and trucks	0	0	0	0	21.00
22.00 Accumulated depreciation	0	0	0	0	22.00
23.00 Major movable equipment	5,044,224	0	0	0	23.00
24.00 Accumulated depreciation	-3,320,870	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)	14,259,193	0	0	0	30.00
OTHER ASSETS					
31.00 Investments	50,241,772	10,151	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	38,057	0	0	0	34.00
35.00 Total other assets (sum of lines 31-34)	50,279,829	10,151	0	0	35.00
36.00 Total assets (sum of lines 11, 30, and 35)	76,373,839	10,151	0	0	36.00
CURRENT LIABILITIES					
37.00 Accounts payable	1,106,108	0	0	0	37.00
38.00 Salaries, wages, and fees payable	2,583,275	0	0	0	38.00
39.00 Payroll taxes payable	0	0	0	0	39.00
40.00 Notes and loans payable (short term)	0	0	0	0	40.00
41.00 Deferred income	0	0	0	0	41.00
42.00 Accelerated payments	0	0	0	0	42.00
43.00 Due to other funds	0	0	0	0	43.00
44.00 Other current liabilities	1,756,588	0	0	0	44.00
45.00 Total current liabilities (sum of lines 37 thru 44)	5,445,971	0	0	0	45.00
LONG TERM LIABILITIES					
46.00 Mortgage payable	0	0	0	0	46.00
47.00 Notes payable	0	0	0	0	47.00
48.00 Unsecured loans	0	0	0	0	48.00
49.00 Other long term liabilities	428,698	0	0	0	49.00
50.00 Total long term liabilities (sum of lines 46 thru 49)	428,698	0	0	0	50.00
51.00 Total liabilities (sum of lines 45 and 50)	5,874,669	0	0	0	51.00
CAPITAL ACCOUNTS					
52.00 General fund balance	70,499,170	0	0	0	52.00
53.00 Specific purpose fund	0	10,151	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)	70,499,170	10,151	0	0	59.00
60.00 Total liabilities and fund balances (sum of lines 51 and 59)	76,373,839	10,151	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 152020

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

Worksheet G-1

Date/Time Prepared:
11/20/2012 4:54 pm

		General Fund		Special Purpose Fund		
		1.00	2.00	3.00	4.00	
		1.00	Fund balances at beginning of period		62,006,191	
2.00	Net income (loss) (from wkst. G-3, line 29)		8,488,585			2.00
3.00	Total (sum of line 1 and line 2)		70,494,776		22,550	3.00
4.00	TRANSFERS FROM AFFILIATES	6,379		0		4.00
5.00	DONATIONS	0		7,601		5.00
6.00	RESTRICTED CONTR. USED	2,262		0		6.00
7.00	OTHER	0		4,248		7.00
8.00	ROUNDING	1		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		8,642		11,849	10.00
11.00	Subtotal (line 3 plus line 10)		70,503,418		34,399	11.00
12.00	OTHER	4,248		0		12.00
13.00	RELEASED FROM RESTRICTIONS	0		24,248		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		4,248		24,248	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		70,499,170		10,151	19.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 152020

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

Worksheet G-1

Date/Time Prepared:
11/20/2012 4:54 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 FROM AFFILIATES						
5.00	0		0			5.00
DONATIONS						
6.00	0		0			6.00
RESTRICTED CONTR. USED						
7.00	0		0			7.00
OTHER						
8.00	0		0			8.00
ROUNDING						
9.00	0		0			9.00
Total additions (sum of line 4-9)		0		0		10.00
10.00		0		0		10.00
Subtotal (line 3 plus line 10)						
11.00		0		0		11.00
OTHER	0		0			12.00
12.00	0		0			12.00
RELEASED FROM RESTRICTIONS						
13.00	0		0			13.00
OTHER						
14.00	0		0			14.00
RELEASD FROM RESTRICTIONS						
15.00	0		0			15.00
OTHER						
16.00	0		0			16.00
OTHER						
17.00	0		0			17.00
OTHER						
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: 152020

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
11/20/2012 4:54 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	39,446,306		39,446,306	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	39,446,306		39,446,306	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	39,446,306		39,446,306	17.00
18.00	Ancillary services	70,553,727	259,315	70,813,042	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to wkst. G-3, line 1)	110,000,033	259,315	110,259,348	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per wkst. A, column 3, line 200)		38,567,462		29.00
30.00	BAD DEBTS	655,801			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)		655,801		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)		39,223,263		43.00

STATEMENT OF REVENUES AND EXPENSES		Provider CCN: 152020	Period: From 07/01/2011 To 06/30/2012	Worksheet G-3 Date/Time Prepared: 11/20/2012 4:54 pm
				1.00
1.00	Total patient revenues (from wkst. G-2, Part I, column 3, line 28)		110,259,348	1.00
2.00	Less contractual allowances and discounts on patients' accounts		62,899,951	2.00
3.00	Net patient revenues (line 1 minus line 2)		47,359,397	3.00
4.00	Less total operating expenses (from wkst. G-2, Part II, line 43)		39,223,263	4.00
5.00	Net income from service to patients (line 3 minus line 4)		8,136,134	5.00
	OTHER INCOME			
6.00	Contributions, donations, bequests, etc		0	6.00
7.00	Income from investments		2,402,825	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		128,659	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		8,927	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)		0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen		1,464	20.00
21.00	Rental of vending machines		0	21.00
22.00	Rental of hospital space		0	22.00
23.00	Governmental appropriations		0	23.00
24.00	OTHER - ASSETS RELEASED FROM RESTR.		21,986	24.00
24.01	OTHER - GRANT INCOME		12,399	24.01
24.02	OTHER - MISC NURSING INCOME		-338	24.02
24.03	OTHER - MISC. PLANT OPS INCOME		3,350	24.03
24.04	OTHER - MISC A&G INCOME		1,324	24.04
24.05	OTHER - NON-CASH PENSION CURTAILMENT		1,140,085	24.05
25.00	Total other income (sum of lines 6-24)		3,720,681	25.00
26.00	Total (line 5 plus line 25)		11,856,815	26.00
27.00	UNREALIZED LOSS		3,368,230	27.00
28.00	Total other expenses (sum of line 27 and subscripts)		3,368,230	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)		8,488,585	29.00