

**ST. VINCENT MERCY HOSPITAL
ELWOOD, INDIANA**

PROVIDER NOS. 15-1308, 15-Z308 AND AIM NO. 100268360

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

JUNE 30, 2011

ST. VINCENT MERCY HOSPITAL

PROVIDER NOS. 15-1308, 15-Z308 AND AIM NO. 100268360

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Accountants' Disclaimer

Hospital Statements of Reimbursable Cost



Board of Trustees
St. Vincent Mercy Hospital
Elwood, Indiana

In accordance with your request, we have compiled the Hospital Statements of Reimbursable Costs (Titles XVIII and XIX) of St. Vincent Mercy Hospital (Provider Nos. 15-1308, 15-Z308 and AIM No. 100268360) for the year ended June 30, 2011 in the accompanying prescribed form in accordance with Statements on Standards for Accounting Review Services issued by the American Institute of Certified Public Accountants.

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

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

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

Bradley Associates

January 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).

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 151308	Period: From 07/01/2010 To 06/30/2011	FORM APPROVED OMB NO. 0938-0050 Worksheet 5 Parts I-III Date/Time Prepared: 1/26/2012 5:52 pm
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PART I -- COST REPORT STATUS

Provider use only	1. <input type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 1/26/2012 Time: 5:52 pm
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II -- CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST. VINCENT MERCY HOSPITAL for the cost reporting period beginning 07/01/2010 and ending 06/30/2011 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: 1/26/2012 Time: 5:52 pm
a6QYL3ysQwX1kv4BmsqikopFO24bB0
crq7z0Gmqup4kne3l7IjiAbzNpUmrR
vRdp0iyvk60lG6Hq
PI: Date: 1/26/2012 Time: 5:52 pm
Qi64zNsluzs.2ONiuq69IKHAge5em0
UOuMZ0M2pj9ELckj7iOC8N1cvr4xNd
kvGJG:eTvi0kwy:N

(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	346,049	209,468	0	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
4.00 SUBPROVIDER I	0	0	0		0	4.00
5.00 Swing bed - SNF	0	31,974	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
7.00 Skilled Nursing Facility	0	0	0		0	7.00
8.00 Nursing Facility	0				0	8.00
9.00 HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00 RURAL HEALTH CLINIC I	0				0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0				0	11.00
12.00 CMHC I	0				0	12.00
200.00 Total	0	378,023	209,468	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: 151308		Period: From 07/01/2010 To 06/30/2011		Worksheet S-2 Part I Date/Time Prepared: 1/26/2012 11:31 am				
1.00		2.00		3.00		4.00						
Hospital and Hospital Health Care Complex Address:												
1.00	Street:13311 SOUTH A ST.			PO Box:							1.00	
2.00	City: ELWOOD		State: IN		Zip Code: 46036-		County: MADISON				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	V	XVIII	XIX	8.00
Hospital and Hospital-Based Component Identification:												
3.00	Hospital		ST. VINCENT MERCY HOSPITAL		151308	11300	1	07/01/2001	N	O	O	3.00
4.00	Subprovider - IPF											4.00
5.00	Subprovider - IRF											5.00
6.00	Subprovider - (Other)											6.00
7.00	Swing Beds - SNF		SWING BED - SNF		152308	11300		07/01/2001	N	O	N	7.00
8.00	Swing Beds - NF								N		N	8.00
9.00	Hospital-Based SNF											9.00
10.00	Hospital-Based NF											10.00
11.00	Hospital-Based OLTC											11.00
12.00	Hospital-Based HHA											12.00
13.00	Separately Certified ASC											13.00
14.00	Hospital-Based Hospice											14.00
15.00	Hospital-Based Health Clinic - RHC											15.00
16.00	Hospital-Based Health Clinic - FQHC											16.00
17.00	Hospital-Based (CMHC) 1											17.00
18.00	Renal Dialysis											18.00
19.00	Other											19.00
								From:	To:			
								1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)							07/01/2010	06/30/2011		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 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 line 22 and/or line 45 is "yes", and 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 days in col. 5, and other Medicaid days in col. 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 column 1, the in State Medicaid eligible days in column 2, the out of State Medicaid paid days in column 3, the out of State Medicaid eligible days in column 4, Medicaid HMO days in column 5, and other Medicaid days in column 6. For all columns include in these days the labor and delivery days.			0	0	0	0	0	0		25.00	
								1.00				
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	Enter your standard geographic classification (not wage) status at the end of the cost reporting period? Enter (1) for urban or (2) for rural.									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: 151308	Period: From 07/01/2010 To 06/30/2011	Worksheet S-2 Part I Date/Time Prepared: 1/26/2012 11:31 am		
		Beginning: 1.00		Ending: 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.			V 1.00	XVIII 2.00	XIX 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.	N				58.00
59.00	Are costs claimed on line 100 of worksheet A? If yes, complete worksheet D-2, Part I.	N				59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N				60.00
		Y/N 1.00	IME Average 2.00	Direct GME Average 3.00		
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011-- enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)	N	0.00	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. If yes, complete lines 64-67. (see instructions)	N				63.00
		Unweighted FTEs Nonprovider Site 1.00	Unweighted FTEs in Hospital 2.00	Ratio (col. 1/ (col. 1 + col. 2)) 3.00		
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	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		64.00
		Program Name 1.00	Program Code 2.00	Unweighted FTEs Nonprovider Site 3.00	Unweighted FTEs in Hospital 4.00	Ratio (col. 3/ (col. 3 + col. 4)) 5.00
65.00	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 occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 151308	Period: From 07/01/2010 To 06/30/2011	Worksheet S-2 Part I Date/Time Prepared: 1/26/2012 11:31 am
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	V	XIX	
	1.00	2.00	

Rural Providers

105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N	N	107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

	Physical	Occupational	Speech	Respiratory
	1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	Y	N

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.	N		115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		1	118.00
119.00	What is the liability limit for the malpractice insurance policy? Enter in column 1 the monetary limit per lawsuit. Enter in column 2 the monetary limit per policy year.		1	119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 as amended by the Medicaid Extender Act (MMEA) §108? Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with <= 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121? Enter in column 2 "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N		121.00

Transplant Center Information

125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00

All Providers

140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	15H046	140.00
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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: NGS	Contractor's Number: 00130	141.00
142.00	Street: 10330 N. MERIDIAN STREET	PO Box:		142.00
143.00	City: INDIANAPOLIS	State: IN	Zip Code: 46290	143.00

		1.00	
144.00	Are provider based physicians' costs included in worksheet A?	Y	144.00
145.00	If costs for renal services are claimed on worksheet A, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.	N	145.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151308		Period: From 07/01/2010 To 06/30/2011		Worksheet S-2 Part I Date/Time Prepared: 1/26/2012 11:31 am	
		1.00			2.00		
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N					146.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N					147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N					148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N					149.00
		Part A		Part B			
		1.00		2.00			
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		155.00
156.00	Subprovider - IPF	N			N		156.00
157.00	Subprovider - IRF	N			N		157.00
158.00	Subprovider - Other	N			N		158.00
159.00	SNF	N			N		159.00
160.00	HHA	N			N		160.00
161.00	CMHC				N		161.00
						1.00	
Multicampus							
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.					N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus
		0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00
						1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.					N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						0.00
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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 151308	Period: From 07/01/2010 To 06/30/2011	Worksheet S-2 Part II Date/Time Prepared: 1/26/2012 11:31 am
		Y/N 1.00	Date 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 1.00	Date 2.00	V/I 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 1.00	Type 2.00	Date 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 1.00	Legal Oper. 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	11/08/2011	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 151308	Period: From 07/01/2010 To 06/30/2011	Worksheet S-2 Part II Date/Time Prepared: 1/26/2012 11:31 am
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	Description	Part A		
		Y/N	Date	
	0	1.00	2.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		21.00
				1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)				
Capital Related Cost				
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N		27.00
Interest Expense				
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	Y		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N		31.00
Purchased Services				
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N		33.00
Provider-Based Physicians				
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	Y		35.00
				Y/N
				Date
				1.00
				2.00
Home Office Costs				
36.00	Were home office costs claimed on the cost report?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		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	11/08/2011	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151308

Period:
From 07/01/2010
To 06/30/2011

Worksheet S-3
Part I
Date/Time Prepared:
1/26/2012 11:31 am

Cost Center Description	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	
	Line Number				
	1.00	2.00	3.00	4.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	25	9,125	44,496.00	1.00
2.00 HMO					2.00
3.00 HMO IPF					3.00
4.00 HMO IRF					4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					5.00
6.00 Hospital Adults & Peds. Swing Bed NF					6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	44,496.00	7.00
8.00 INTENSIVE CARE UNIT	31.00	0	0	0.00	8.00
9.00 CORONARY CARE UNIT					9.00
10.00 BURN INTENSIVE CARE UNIT					10.00
11.00 SURGICAL INTENSIVE CARE UNIT					11.00
12.00 OTHER SPECIAL CARE (SPECIFY)					12.00
13.00 NURSERY					13.00
14.00 Total (see instructions)		25	9,125	44,496.00	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)		25			27.00
28.00 Observation Bed Days					28.00
29.00 Ambulance Trips					29.00
30.00 Employee discount days (see instruction)					30.00
31.00 Employee discount days - IRF					31.00
32.00 Labor & delivery days (see instructions)					32.00
33.00 LTCH non-covered days					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA	Provider CCN: 151308	Period: From 07/01/2010 To 06/30/2011	Worksheet S-3 Part I Date/Time Prepared: 1/26/2012 11:31 am
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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	1,159	144	1,854		1.00
2.00 HMO		0	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	727	0	727		5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0		0	141		6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	0	1,886	144	2,722		7.00
8.00 INTENSIVE CARE UNIT	0	0	0	0		8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0	1,886	144	2,722		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	386		28.00
29.00 Ambulance Trips		2				29.00
30.00 Employee discount days (see instruction)				35		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: 151308

Period:
From 07/01/2010
To 06/30/2011

Worksheet S-3
Part I
Date/Time Prepared:
1/26/2012 11:31 am

Cost Center Description	Full Time Equivalents			Discharges		
	Total Interns & Residents	Employees On Payroll	Nonpaid workers	Title V	Title XVIII	
	9.00	10.00	11.00	12.00	13.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)				0	308	1.00
2.00 HMO					0	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	184.37	0.00	0	308	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	184.37	0.00			27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151308

Period:
From 07/01/2010
To 06/30/2011

Worksheet S-3
Part I
Date/Time Prepared:
1/26/2012 11:31 am

Cost Center Description	Discharges			
	Title XIX	Total All Patients		
	14.00	15.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	42	522		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)	42	522		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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 151308	Period: From 07/01/2010 To 06/30/2011	Worksheet S-10 Date/Time Prepared: 1/26/2012 11:31 am
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			1.00	
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 200 column 3 divided by line 200 column 8)		0.454361	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		1,145,132	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		N	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?			4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		0	5.00
6.00	Medicaid charges		8,383,102	6.00
7.00	Medicaid cost (line 1 times line 6)		3,808,955	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		2,663,823	8.00
State Children's Health Insurance Program (SCHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone SCHIP		0	9.00
10.00	Stand-alone SCHIP charges		0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)		0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00
Uncompensated care (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		33,117	18.00
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		2,663,823	19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)
		1.00	2.00	3.00
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	4,442,674	0	4,442,674
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	2,018,578	0	2,018,578
22.00	Partial payment by patients approved for charity care	0	0	0
23.00	Cost of charity care (line 21 minus line 22)	2,018,578	0	2,018,578
				1.00
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit		0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		3,220,565	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		542,407	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)		2,678,158	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)		1,216,851	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)		3,235,429	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		5,899,252	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151308

Period:
From 07/01/2010
To 06/30/2011

Worksheet A

Date/Time Prepared:
1/26/2012 11:31 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassificati ons (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	NEW CAP REL COSTS-BLDG & FIXT		1,089,916	1,089,916	-122,779	967,137	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP		755,856	755,856	0	755,856	2.00
3.00	OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00	EMPLOYEE BENEFITS	202,431	3,636,627	3,839,058	0	3,839,058	4.00
5.00	ADMINISTRATIVE & GENERAL	2,417,334	1,851,018	4,268,352	122,779	4,391,131	5.00
7.00	OPERATION OF PLANT	317,624	535,842	853,466	0	853,466	7.00
8.00	LAUNDRY & LINEN SERVICE	0	0	0	41,207	41,207	8.00
9.00	HOUSEKEEPING	290,838	62,104	352,942	-41,207	311,735	9.00
10.00	DIETARY	243,375	125,117	368,492	-228,167	140,325	10.00
11.00	CAFETERIA	0	0	0	228,167	228,167	11.00
13.00	NURSING ADMINISTRATION	112,466	13,120	125,586	0	125,586	13.00
15.00	PHARMACY	374,423	1,701,534	2,075,957	0	2,075,957	15.00
16.00	MEDICAL RECORDS & LIBRARY	166,216	57,978	224,194	0	224,194	16.00
17.00	SOCIAL SERVICE	106,053	50,290	156,343	0	156,343	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	1,264,672	137,205	1,401,877	68,018	1,469,895	30.00
31.00	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	503,123	389,857	892,980	22,766	915,746	50.00
54.00	RADIOLOGY-DIAGNOSTIC	1,123,731	1,072,832	2,196,563	0	2,196,563	54.00
56.00	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	CT SCAN	0	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	LABORATORY	136,921	992,052	1,128,973	0	1,128,973	60.00
65.00	RESPIRATORY THERAPY	449,403	79,757	529,160	20,117	549,277	65.00
66.00	PHYSICAL THERAPY	442,017	25,871	467,888	0	467,888	66.00
67.00	OCCUPATIONAL THERAPY	5,834	22,138	27,972	0	27,972	67.00
68.00	SPEECH PATHOLOGY	0	41,967	41,967	0	41,967	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	43,490	43,490	-43,490	0	71.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	48	48	73.00
76.00	SLEEP LAB	0	0	0	0	0	76.00
76.01	ONCOLOGY	124,283	58,177	182,460	23,188	205,648	76.01
76.02	ECLIPSYS	0	0	0	0	0	76.02
76.03	WOUND CARE	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS							
90.00	CLINIC	101,396	7,986	109,382	-93,050	16,332	90.00
91.00	EMERGENCY	2,157,824	142,581	2,300,405	2,403	2,302,808	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	10,539,964	12,893,315	23,433,279	0	23,433,279	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	MARKETING	0	179	179	0	179	194.00
194.01	FOUNDATION	-1,863	1,078	-785	0	-785	194.01
194.02	CLINIC	0	0	0	0	0	194.02
194.03	VACANT	0	0	0	0	0	194.03
200.00	TOTAL (SUM OF LINES 118-199)	10,538,101	12,894,572	23,432,673	0	23,432,673	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151308

Period:
From 07/01/2010
To 06/30/2011

Worksheet A

Date/Time Prepared:
1/26/2012 11:31 am

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
		6.00	7.00	
GENERAL SERVICE COST CENTERS				
1.00	NEW CAP REL COSTS-BLDG & FIXT	-372,019	595,118	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	755,856	2.00
3.00	OTHER CAPITAL RELATED COSTS	0	0	3.00
4.00	EMPLOYEE BENEFITS	381,166	4,220,224	4.00
5.00	ADMINISTRATIVE & GENERAL	114,969	4,506,100	5.00
7.00	OPERATION OF PLANT	0	853,466	7.00
8.00	LAUNDRY & LINEN SERVICE	0	41,207	8.00
9.00	HOUSEKEEPING	0	311,735	9.00
10.00	DIETARY	-75,399	64,926	10.00
11.00	CAFETERIA	0	228,167	11.00
13.00	NURSING ADMINISTRATION	0	125,586	13.00
15.00	PHARMACY	-65,475	2,010,482	15.00
16.00	MEDICAL RECORDS & LIBRARY	-9,869	214,325	16.00
17.00	SOCIAL SERVICE	0	156,343	17.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	-26,403	1,443,492	30.00
31.00	INTENSIVE CARE UNIT	0	0	31.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	-15,003	900,743	50.00
54.00	RADIOLOGY-DIAGNOSTIC	-575,957	1,620,606	54.00
56.00	RADIOISOTOPE	0	0	56.00
57.00	CT SCAN	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
60.00	LABORATORY	-1,830	1,127,143	60.00
65.00	RESPIRATORY THERAPY	-19,882	529,395	65.00
66.00	PHYSICAL THERAPY	-7,044	460,844	66.00
67.00	OCCUPATIONAL THERAPY	-7,601	20,371	67.00
68.00	SPEECH PATHOLOGY	0	41,967	68.00
69.00	ELECTROCARDIOLOGY	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
73.00	DRUGS CHARGED TO PATIENTS	0	48	73.00
76.00	SLEEP LAB	0	0	76.00
76.01	ONCOLOGY	-30,068	175,580	76.01
76.02	ECLIPSYS	0	0	76.02
76.03	WOUND CARE	0	0	76.03
OUTPATIENT SERVICE COST CENTERS				
90.00	CLINIC	-45	16,287	90.00
91.00	EMERGENCY	-450,469	1,852,339	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
SPECIAL PURPOSE COST CENTERS				
118.00	SUBTOTALS (SUM OF LINES 1-117)	-1,160,929	22,272,350	118.00
NONREIMBURSABLE COST CENTERS				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
194.00	MARKETING	301,198	301,377	194.00
194.01	FOUNDATION	0	-785	194.01
194.02	CLINIC	0	0	194.02
194.03	VACANT	0	0	194.03
200.00	TOTAL (SUM OF LINES 118-199)	-859,731	22,572,942	200.00

RECLASSIFICATIONS

Provider CCN: 151308

Period:
From 07/01/2010
To 06/30/2011

Worksheet A-6

Date/Time Prepared:
1/26/2012 11:31 am

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - CAFETERIA					
1.00	CAFETERIA	11.00	148,605	79,562	1.00
	TOTALS		148,605	79,562	
B - LAUNDRY					
1.00	LAUNDRY & LINEN SERVICE	8.00	33,956	7,251	1.00
	TOTALS		33,956	7,251	
C - INTEREST					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	122,779	1.00
	TOTALS		0	122,779	
D - SUPPLIES					
1.00	ADULTS & PEDIATRICS	30.00	0	159	1.00
2.00	OPERATING ROOM	50.00	0	21,661	2.00
3.00	RESPIRATORY THERAPY	65.00	0	19,920	3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0	48	4.00
5.00	ONCOLOGY	76.01	0	98	5.00
6.00	CLINIC	90.00	0	65	6.00
7.00	EMERGENCY	91.00	0	1,539	7.00
	TOTALS		0	43,490	
E - CLINIC RECLASS					
1.00	ADULTS & PEDIATRICS	30.00	62,906	4,953	1.00
2.00	OPERATING ROOM	50.00	1,024	81	2.00
3.00	RESPIRATORY THERAPY	65.00	183	14	3.00
4.00	ONCOLOGY	76.01	21,405	1,685	4.00
5.00	EMERGENCY	91.00	801	63	5.00
	TOTALS		86,319	6,796	
500.00	Grand Total: Increases		268,880	259,878	500.00

		Decreases				Wkst. A-7 Ref.	
Cost Center	Line #	Salary	Other				
6.00	7.00	8.00	9.00	10.00			
A - CAFETERIA							
1.00	DIETARY	10.00	148,605	79,562	0		1.00
	TOTALS		148,605	79,562			
B - LAUNDRY							
1.00	HOUSEKEEPING	9.00	33,956	7,251	0		1.00
	TOTALS		33,956	7,251			
C - INTEREST							
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	122,779	9		1.00
	TOTALS		0	122,779			
D - SUPPLIES							
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	43,490	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
	TOTALS		0	43,490			
E - CLINIC RECLASS							
1.00	CLINIC	90.00	86,319	6,796	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
	TOTALS		86,319	6,796			
500.00	Grand Total: Decreases		268,880	259,878			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151308

Period:
From 07/01/2010
To 06/30/2011

Worksheet A-7
Parts I-III
Date/Time Prepared:
1/26/2012 11:31 am

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	457,300	0	0	0	1.00
2.00	Land Improvements	507,925	29,492	0	29,492	2.00
3.00	Buildings and Fixtures	27,008,607	778,308	0	778,308	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)	27,973,832	807,800	0	807,800	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	27,973,832	807,800	0	807,800	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	NEW CAP REL COSTS-BLDG & FIXT	1,089,916	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	755,856	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,845,772	0	0	0	3.00
COMPUTATION OF RATIOS						
Cost Center Description		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL Ratio (see instructions)	Insurance
		1.00	2.00	3.00	4.00	5.00
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	28,781,632	0	28,781,632	1.000000	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	2.00
3.00	Total (sum of lines 1-2)	28,781,632	0	28,781,632	1.000000	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151308

Period:
From 07/01/2010
To 06/30/2011

Worksheet A-7
Parts I-III
Date/Time Prepared:
1/26/2012 11:31 am

		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	457,300	0		1.00		
2.00	Land Improvements	537,417	0		2.00		
3.00	Buildings and Fixtures	27,786,915	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)	28,781,632	0		8.00		
9.00	Reconciling Items	0	0		9.00		
10.00	Total (line 8 minus line 9)	28,781,632	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	NEW CAP REL COSTS-BLDG & FIXT	0	1,089,916		1.00		
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	755,856		2.00		
3.00	Total (sum of lines 1-2)	0	1,845,772		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	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	595,118	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	755,856	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,350,974	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151308

Period:
From 07/01/2010
To 06/30/2011

Worksheet A-7
Parts I-III
Date/Time Prepared:
1/26/2012 11:31 am

Cost Center Description		SUMMARY OF CAPITAL					Total (2) (sum of cols. 9 through 14)	
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
		11.00	12.00	13.00	14.00	15.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS								
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	595,118	1.00	
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	755,856	2.00	
3.00	Total (sum of lines 1-2)	0	0	0	0	1,350,974	3.00	

ADJUSTMENTS TO EXPENSES

Provider CCN: 151308

Period:
From 07/01/2010
To 06/30/2011

Worksheet A-8

Date/Time Prepared:
1/26/2012 11:31 am

		Expense Classification on Worksheet A To/From which the Amount is to be Adjusted				
		Basis/Code (2)	Amount	Cost Center	Line #	
		1.00	2.00	3.00	4.00	
1.00	Investment income - buildings and fixtures (chapter 2)	B	-404,525	NEW CAP REL COSTS-BLDG & FIXT	1.00	1.00
2.00	Investment income - movable equipment (chapter 2)			NEW CAP REL COSTS-MVBLE EQUIP	2.00	2.00
3.00	Investment income - other (chapter 2)	B	-149,668	ADMINISTRATIVE & GENERAL	5.00	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-7,773	ADMINISTRATIVE & GENERAL	5.00	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	-1,075,421			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	1,030,094			12.00
13.00	Laundry and linen service		0		0.00	13.00
14.00	Cafeteria-employees and guests	B	-75,399	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	B	-65,442	PHARMACY	15.00	17.00
18.00	Sale of medical records and abstracts	B	-9,869	MEDICAL RECORDS & LIBRARY	16.00	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	19.00
20.00	Vending machines		0		0.00	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00	23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00	24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00	25.00
26.00	Depreciation - buildings and fixtures		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	26.00
27.00	Depreciation - movable equipment		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00	28.00
29.00	Physicians' assistant		0		0.00	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00	30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00	31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	32.00
33.00	PT REVENUE	B	-7,044	PHYSICAL THERAPY	66.00	33.00
34.00	ADMIN REVENUE	B	-44,718	ADMINISTRATIVE & GENERAL	5.00	34.00
35.00	LAB REVENUE	B	-1,830	LABORATORY	60.00	35.00
35.01	RADIOLOGY REVENUE	B	-5,364	RADIOLOGY-DIAGNOSTIC	54.00	35.01
36.00	LOBBYING	A	-1,043	ADMINISTRATIVE & GENERAL	5.00	36.00
37.00	RADIOLOGY PURCHASED SVCS	A	-30,243	RADIOLOGY-DIAGNOSTIC	54.00	37.00
38.00	O/R SUPPLIES	B	-15,003	OPERATING ROOM	50.00	38.00
39.00	RT SUPPLIES	B	-13,798	RESPIRATORY THERAPY	65.00	39.00
40.00	A&P SUPPLIES	B	-110	ADULTS & PEDIATRICS	30.00	40.00
41.00	ONCOLOGY SUPPLIES	B	-68	ONCOLOGY	76.01	41.00
42.00	DRUGS SUPPLIES	B	-33	PHARMACY	15.00	42.00
42.04	CLINIC SUPPLIES	B	-45	CLINIC	90.00	42.04
42.05			0		0.00	42.05
42.06	ER SUPPLIES	B	-1,066	EMERGENCY	91.00	42.06
42.07	CSI SERVICING FEES	A	19,732	ADMINISTRATIVE & GENERAL	5.00	42.07
42.08	ENTERTAINMENT	A	-983	ADMINISTRATIVE & GENERAL	5.00	42.08
42.09	ENTERTAINMENT	A	-112	ADMINISTRATIVE & GENERAL	5.00	42.09
42.10			0		0.00	42.10
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200.)		-859,731			50.00

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		Wkst. A-7 Ref.	
		5.00	
1.00	Investment income - buildings and fixtures (chapter 2)	9	1.00
2.00	Investment income - movable equipment (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 - buildings and fixtures	0	26.00
27.00	Depreciation - movable equipment	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	PT REVENUE	0	33.00
34.00	ADMIN REVENUE	0	34.00
35.00	LAB REVENUE	0	35.00
35.01	RADIOLOGY REVENUE	0	35.01
36.00	LOBBYING	0	36.00
37.00	RADIOLOGY PURCHASED SVCS	0	37.00
38.00	O/R SUPPLIES	0	38.00
39.00	RT SUPPLIES	0	39.00
40.00	A&P SUPPLIES	0	40.00
41.00	ONCOLOGY SUPPLIES	0	41.00
42.00	DRUGS SUPPLIES	0	42.00
42.04	CLINIC SUPPLIES	0	42.04
42.05		0	42.05
42.06	ER SUPPLIES	0	42.06
42.07	CSI SERVICING FEES	0	42.07
42.08	ENTERTAINMENT	0	42.08
42.09	ENTERTAINMENT	0	42.09
42.10		0	42.10
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: 151308

Period:
From 07/01/2010
To 06/30/2011

Worksheet A-8-1

Date/Time Prepared:
1/26/2012 11:31 am

	Line No.	Cost Center	Expense Items	
	1.00	2.00	3.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	1.00	NEW CAP REL COSTS-BLDG & FIXT	HOME OFFICE	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	2.00
3.00	194.00	MARKETING	HOME OFFICE	3.00
4.00	0.00			4.00
4.01	60.00	LABORATORY	ST. VINCENT HEALTH - CHG	4.01
4.02	65.00	RESPIRATORY THERAPY	ST. VINCENT HEALTH - CHG	4.02
4.03	71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	ST. VINCENT HEALTH - CHG	4.03
4.06	15.00	PHARMACY	ST. VINCENT HEALTH - CHG	4.06
4.07	16.00	MEDICAL RECORDS & LIBRARY	ST. VINCENT HEALTH - CHG	4.07
4.08	54.00	RADIOLOGY-DIAGNOSTIC	ST. VINCENT HEALTH - CHG	4.08
4.09	4.00	EMPLOYEE BENEFITS	ST. VINCENT HEALTH - CHG	4.09
4.10	5.00	ADMINISTRATIVE & GENERAL	ST. VINCENT HEALTH - CHG	4.10
4.16	1.00	NEW CAP REL COSTS-BLDG & FIXT	ASCENSION INTEREST	4.16
4.17	5.00	ADMINISTRATIVE & GENERAL	ASCENSION INTEREST	4.17
4.19	5.00	ADMINISTRATIVE & GENERAL	ASCENSION MAINTENANCE	4.19
4.23	4.00	EMPLOYEE BENEFITS	SELF INSURANCE	4.23
4.24	4.00	EMPLOYEE BENEFITS	PENSION	4.24
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to worksheet A-8, column 2, line 12.			5.00

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

	Symbol (1)	Name	Percentage of Ownership	
	1.00	2.00	3.00	

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

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

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

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

	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	252,993	0	252,993	9	1.00
2.00	2,067,617	1,644,583	423,034	0	2.00
3.00	301,198	0	301,198	0	3.00
4.00	0	0	0	0	4.00
4.01	2,225	2,225	0	0	4.01
4.02	22,992	22,992	0	0	4.02
4.03	1,332	1,332	0	0	4.03
4.06	68,064	68,064	0	0	4.06
4.07	88,741	88,741	0	0	4.07
4.08	18,841	18,841	0	0	4.08
4.09	351,014	351,014	0	0	4.09
4.10	934,371	934,371	0	0	4.10
4.16	111,364	331,851	-220,487	9	4.16
4.17	41,203	122,779	-81,576	0	4.17
4.19	350,698	376,932	-26,234	0	4.19
4.23	1,833,138	1,451,972	381,166	0	4.23
4.24	730,716	730,716	0	0	4.24
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to worksheet A-8, column 2, line 12.	7,176,507	6,146,413	1,030,094	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 HEALTH	100.00	ADMINISTRATION	6.00
7.00	ASCENSION	100.00	ADMINISTRATION	7.00
8.00	ST. VINCENT HOSPITAL	100.00	HOSPITAL	8.00
9.00		0.00		9.00
10.00		0.00		10.00
100.00	G. other (financial or non-financial) specify:			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151308

Period:
From 07/01/2010
To 06/30/2011

Worksheet A-8-2

Date/Time Prepared:
1/26/2012 11:31 am

	1.00	2.00	3.00	4.00	
	Cost Center/Physician Identifier		Total Remuneration	Professional Component	
1.00	91.00	EMERGENCY	1,000,725	449,403	1.00
2.00	5.00	MEDICAL DIRECTOR	15,690	15,690	2.00
3.00	76.01	ONCOLOGY	30,000	30,000	3.00
4.00	67.00	OCCUPATIONAL THERAPY	7,601	7,601	4.00
5.00	30.00	ADULTS & Peds	26,293	26,293	5.00
6.00	54.00	RADIOLOGY	540,350	540,350	6.00
7.00	65.00	RESPIRATORY THERAPY	6,084	6,084	7.00
8.00	0.00		0	0	8.00
9.00	0.00		0	0	9.00
10.00	0.00		0	0	10.00
200.00	TOTAL (lines 1.00 through 199.00)		1,626,743	1,075,421	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151308

Period:
From 07/01/2010
To 06/30/2011

Worksheet A-8-2

Date/Time Prepared:
1/26/2012 11:31 am

	Provider Component	RCE Amount	Physician/Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	5.00	6.00	7.00	8.00	9.00	
1.00	551,322	0	0	0	0	1.00
2.00	0	0	0	0	0	2.00
3.00	0	0	0	0	0	3.00
4.00	0	0	0	0	0	4.00
5.00	0	0	0	0	0	5.00
6.00	0	0	0	0	0	6.00
7.00	0	0	0	0	0	7.00
8.00	0	0	0	0	0	8.00
9.00	0	0	0	0	0	9.00
10.00	0	0	0	0	0	10.00
200.00	551,322					200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151308

Period:
From 07/01/2010
To 06/30/2011

Worksheet A-8-2

Date/Time Prepared:
1/26/2012 11:31 am

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151308

Period:
From 07/01/2010
To 06/30/2011

Worksheet A-8-2

Date/Time Prepared:
1/26/2012 11:31 am

	RCE Disallowance	Adjustment	
	17.00	18.00	
1.00	0	449,403	1.00
2.00	0	15,690	2.00
3.00	0	30,000	3.00
4.00	0	7,601	4.00
5.00	0	26,293	5.00
6.00	0	540,350	6.00
7.00	0	6,084	7.00
8.00	0	0	8.00
9.00	0	0	9.00
10.00	0	0	10.00
200.00	0	1,075,421	200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 151308	Period: From 07/01/2010 To 06/30/2011	Worksheet A-8-3 Par Date/Time Prepared: 1/26/2012 11:31 am
		Occupational Therapy	Cost

	1.00	
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PART I - GENERAL INFORMATION			
1.00	Total number of weeks worked (excluding aides) (see instructions)	29	1.00
2.00	Line 1 multiplied by 15 hours per week	435	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)	88	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)	0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)	0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)	0	6.00
7.00	Standard travel expense rate	4.85	7.00
8.00	Optional travel expense rate per mile	0.00	8.00

	Supervisors	Therapists	Assistants	Aides	Trainees		
	1.00	2.00	3.00	4.00	5.00		
9.00	Total hours worked	0.00	192.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	69.45	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	34.72	34.72	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01

	1.00	
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Part II - SALARY EQUIVALENCY COMPUTATION			
14.00	Supervisors (column 1, line 9 times column 1, line 10)	0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)	13,334	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)	0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	13,334	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)	0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)	0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	13,334	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.			
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)	69.45	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	30,211	22.00
23.00	Total salary equivalency (see instructions)	30,211	23.00

PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE			
Standard Travel Allowance			
24.00	Therapists (line 3 times column 2, line 11)	3,055	24.00
25.00	Assistants (line 4 times column 3, line 11)	0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	3,055	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	427	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	3,482	28.00
Optional Travel Allowance and Optional Travel Expense			
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)	0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)	0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)	0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00

Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE			
Standard Travel Expense			
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
Optional Travel Allowance and Optional Travel Expense			
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.			
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 151308	Period: From 07/01/2010 To 06/30/2011	Worksheet A-8-3 Par Date/Time Prepared: 1/26/2012 11:31 am
		Occupational Therapy	Cost

45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					1.00	0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)						0	46.00
		Therapists	Assistants	Aides	Trainees	Total		
		1.00	2.00	3.00	4.00	5.00		

PART V - OVERTIME COMPUTATION								
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00	0.00	0.00	48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00	0.00	0.00	49.00
CALCULATION OF LIMIT								
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	0.00	51.00
DETERMINATION OF OVERTIME ALLOWANCE								
52.00	Adjusted hourly salary equivalency amount (see instructions)	69.45	0.00	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	0	56.00

						1.00		
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Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT								
57.00	Salary equivalency amount (from line 23)						30,211	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))						0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)						0	59.00
60.00	Overtime allowance (from column 5, line 56)						0	60.00
61.00	Equipment cost (see instructions)						0	61.00
62.00	Supplies (see instructions)						0	62.00
63.00	Total allowance (sum of lines 57-62)						30,211	63.00
64.00	Total cost of outside supplier services (from your records)						12,841	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)						0	65.00

LINE 33 CALCULATION								
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others						3,055	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						427	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27						3,482	100.02
LINE 34 CALCULATION								
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						427	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	101.01
101.02	Line 34 = sum of lines 27 and 31						427	101.02
LINE 35 CALCULATION								
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others						0	102.01
102.02	Line 35 = sum of lines 31 and 32						0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 151308	Period: From 07/01/2010 To 06/30/2011	Worksheet A-8-3 Par Date/Time Prepared: 1/26/2012 11:31 am
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	Speech Pathology	Cost	
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PART I - GENERAL INFORMATION			
		1.00	
1.00	Total number of weeks worked (excluding aides) (see instructions)		58 1.00
2.00	Line 1 multiplied by 15 hours per week		870 2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		186 3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)		0 4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)		0 5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)		0 6.00
7.00	Standard travel expense rate	0.00	7.00
8.00	Optional travel expense rate per mile	0.00	8.00

	Supervisors	Therapists	Assistants	Aides	Trainees		
	1.00	2.00	3.00	4.00	5.00		
9.00	Total hours worked	0.00	504.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	66.75	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	33.38	33.38	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01

						1.00
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Part II - SALARY EQUIVALENCY COMPUTATION			
14.00	Supervisors (column 1, line 9 times column 1, line 10)		0 14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)		33,642 15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)		0 16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)		33,642 17.00
18.00	Aides (column 4, line 9 times column 4, line 10)		0 18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)		0 19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)		33,642 20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.			
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)		66.75 21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)		58,073 22.00
23.00	Total salary equivalency (see instructions)		58,073 23.00

PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE

Standard Travel Allowance			
24.00	Therapists (line 3 times column 2, line 11)		6,209 24.00
25.00	Assistants (line 4 times column 3, line 11)		0 25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)		6,209 26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)		0 27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)		6,209 28.00
Optional Travel Allowance and Optional Travel Expense			
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)		0 29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)		0 30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)		0 31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)		0 32.00
33.00	Standard travel allowance and standard travel expense (line 28)		0 33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)		0 34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)		0 35.00

PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE

Standard Travel Expense			
36.00	Therapists (line 5 times column 2, line 11)		0 36.00
37.00	Assistants (line 6 times column 3, line 11)		0 37.00
38.00	Subtotal (sum of lines 36 and 37)		0 38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)		0 39.00
Optional Travel Allowance and Optional Travel Expense			
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)		0 40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)		0 41.00
42.00	Subtotal (sum of lines 40 and 41)		0 42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)		0 43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.			
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)		0 44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)		0 45.00

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 151308	Period: From 07/01/2010 To 06/30/2011	Worksheet A-8-3 Par Date/Time Prepared: 1/26/2012 11:31 am
		Speech Pathology	Cost

46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					1.00	0	46.00
		Therapists	Assistants	Aides	Trainees	Total		
		1.00	2.00	3.00	4.00	5.00		

PART V - OVERTIME COMPUTATION

47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00		47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00	0.00		49.00
CALCULATION OF LIMIT								
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00		50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00		51.00
DETERMINATION OF OVERTIME ALLOWANCE								
52.00	Adjusted hourly salary equivalency amount (see instructions)	66.75	0.00	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0		56.00

						1.00		
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Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57.00	Salary equivalency amount (from line 23)						58,073	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))						0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)						0	59.00
60.00	Overtime allowance (from column 5, line 56)						0	60.00
61.00	Equipment cost (see instructions)						0	61.00
62.00	Supplies (see instructions)						0	62.00
63.00	Total allowance (sum of lines 57-62)						58,073	63.00
64.00	Total cost of outside supplier services (from your records)						41,654	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)						0	65.00

LINE 33 CALCULATION

100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others						6,209	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27						6,209	100.02

LINE 34 CALCULATION

101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	101.01
101.02	Line 34 = sum of lines 27 and 31						0	101.02

LINE 35 CALCULATION

102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others						0	102.01
102.02	Line 35 = sum of lines 31 and 32						0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151308

Period:
From 07/01/2010
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Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	595,118	595,118			1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	755,856		755,856		2.00
4.00	EMPLOYEE BENEFITS	4,220,224	4,272	298	4,224,794	4.00
5.00	ADMINISTRATIVE & GENERAL	4,506,100	221,279	45,355	987,927	5,760,661
7.00	OPERATION OF PLANT	853,466	90,096	24,748	129,808	1,098,118
8.00	LAUNDRY & LINEN SERVICE	41,207	7,109	0	13,877	62,193
9.00	HOUSEKEEPING	311,735	4,333	1,767	104,984	422,819
10.00	DIETARY	64,926	11,789	5,385	38,731	120,831
11.00	CAFETERIA	228,167	7,477	0	60,733	296,377
13.00	NURSING ADMINISTRATION	125,586	8,615	2,139	45,963	182,303
15.00	PHARMACY	2,010,482	6,629	34,559	153,021	2,204,691
16.00	MEDICAL RECORDS & LIBRARY	214,325	10,386	0	67,930	292,641
17.00	SOCIAL SERVICE	156,343	2,644	3,107	43,342	205,436
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,443,492	40,623	56,040	542,561	2,082,716
31.00	INTENSIVE CARE UNIT	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	900,743	39,883	105,951	206,037	1,252,614
54.00	RADIOLOGY-DIAGNOSTIC	1,620,606	25,604	432,148	459,252	2,537,610
56.00	RADIOISOTOPE	0	0	0	0	0
57.00	CT SCAN	0	0	0	0	0
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
60.00	LABORATORY	1,127,143	11,212	9,751	55,958	1,204,064
65.00	RESPIRATORY THERAPY	529,395	12,549	5,513	183,739	731,196
66.00	PHYSICAL THERAPY	460,844	26,303	3,016	180,646	670,809
67.00	OCCUPATIONAL THERAPY	20,371	929	0	2,384	23,684
68.00	SPEECH PATHOLOGY	41,967	0	0	0	41,967
69.00	ELECTROCARDIOLOGY	0	0	0	0	0
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
73.00	DRUGS CHARGED TO PATIENTS	48	0	0	0	48
76.00	SLEEP LAB	0	0	0	0	0
76.01	ONCOLOGY	175,580	1,766	382	59,541	237,269
76.02	ECLIPSYS	0	0	0	0	0
76.03	WOUND CARE	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	16,287	7,385	1,745	6,162	31,579
91.00	EMERGENCY	1,852,339	36,832	23,952	882,198	2,795,321
92.00	OBSERVATION BEDS (NON-DISTINCT PART)					0
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	22,272,350	577,715	755,856	4,224,794	22,254,947
NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,730	0	0	1,730
192.00	PHYSICIANS' PRIVATE OFFICES	0	7,982	0	0	7,982
194.00	MARKETING	301,377	2,603	0	0	303,980
194.01	FOUNDATION	-785	1,587	0	0	802
194.02	CLINIC	0	0	0	0	0
194.03	VACANT	0	3,501	0	0	3,501
200.00	Cross Foot Adjustments					0
201.00	Negative Cost Centers		0	0	0	0
202.00	TOTAL (sum lines 118-201)	22,572,942	595,118	755,856	4,224,794	22,572,942

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151308

Period:
From 07/01/2010
To 06/30/2011

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Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY		
	5.00	7.00	8.00	9.00	10.00		
GENERAL SERVICE COST CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT					1.00	
2.00	NEW CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	EMPLOYEE BENEFITS					4.00	
5.00	ADMINISTRATIVE & GENERAL	5,760,661				5.00	
7.00	OPERATION OF PLANT	376,266	1,474,384			7.00	
8.00	LAUNDRY & LINEN SERVICE	21,310	37,505	121,008		8.00	
9.00	HOUSEKEEPING	144,877	22,858	24,170	614,724	9.00	
10.00	DIETARY	41,402	62,194	2,333	6,187	232,947	10.00
11.00	CAFETERIA	101,552	39,444	3,603	0	0	11.00
13.00	NURSING ADMINISTRATION	62,465	45,448	0	4,455	0	13.00
15.00	PHARMACY	755,429	34,974	0	15,343	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	100,272	54,790	0	6,434	0	16.00
17.00	SOCIAL SERVICE	70,392	13,947	0	3,217	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	713,634	214,316	39,775	201,194	232,947	30.00
31.00	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	429,203	210,411	13,422	82,656	0	50.00
54.00	RADIOLOGY-DIAGNOSTIC	869,502	135,078	9,396	38,606	0	54.00
56.00	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	CT SCAN	0	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	LABORATORY	412,568	59,152	1,368	47,020	0	60.00
65.00	RESPIRATORY THERAPY	250,541	66,206	0	40,586	0	65.00
66.00	PHYSICAL THERAPY	229,850	138,766	5,904	46,278	0	66.00
67.00	OCCUPATIONAL THERAPY	8,115	4,900	0	0	0	67.00
68.00	SPEECH PATHOLOGY	14,380	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	DRUGS CHARGED TO PATIENTS	16	0	0	0	0	73.00
76.00	SLEEP LAB	0	0	0	0	0	76.00
76.01	ONCOLOGY	81,299	9,316	0	11,384	0	76.01
76.02	ECLIPSYS	0	0	0	0	0	76.02
76.03	WOUND CARE	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS							
90.00	CLINIC	10,820	38,959	0	3,465	0	90.00
91.00	EMERGENCY	957,807	194,310	21,037	102,207	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	5,651,700	1,382,574	121,008	609,032	232,947	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	593	9,127	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	2,735	42,109	0	0	0	192.00
194.00	MARKETING	104,158	13,731	0	3,465	0	194.00
194.01	FOUNDATION	275	8,373	0	2,227	0	194.01
194.02	CLINIC	0	0	0	0	0	194.02
194.03	VACANT	1,200	18,470	0	0	0	194.03
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	5,760,661	1,474,384	121,008	614,724	232,947	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151308

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Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		11.00	13.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
7.00	OPERATION OF PLANT						7.00
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING						9.00
10.00	DIETARY						10.00
11.00	CAFETERIA	440,976					11.00
13.00	NURSING ADMINISTRATION	8,134	302,805				13.00
15.00	PHARMACY	18,025	13,937	3,042,399			15.00
16.00	MEDICAL RECORDS & LIBRARY	19,255	0	0	473,392		16.00
17.00	SOCIAL SERVICE	8,524	4,983	0	0	306,499	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	109,651	84,783	0	21,302	297,286	30.00
31.00	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	35,472	27,427	0	75,063	0	50.00
54.00	RADIOLOGY-DIAGNOSTIC	69,865	54,020	0	131,778	0	54.00
56.00	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	CT SCAN	0	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	LABORATORY	12,761	9,867	0	66,630	0	60.00
65.00	RESPIRATORY THERAPY	32,487	25,119	0	20,441	0	65.00
66.00	PHYSICAL THERAPY	28,183	21,792	0	19,058	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	1,346	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	1,532	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	3,042,399	64,469	0	73.00
76.00	SLEEP LAB	0	0	0	0	0	76.00
76.01	ONCOLOGY	9,210	7,122	0	4,583	0	76.01
76.02	ECLIPSYS	0	0	0	0	0	76.02
76.03	WOUND CARE	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS							
90.00	CLINIC	1,375	1,063	0	886	0	90.00
91.00	EMERGENCY	86,831	52,692	0	66,304	9,213	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	439,773	302,805	3,042,399	473,392	306,499	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	MARKETING	0	0	0	0	0	194.00
194.01	FOUNDATION	1,203	0	0	0	0	194.01
194.02	CLINIC	0	0	0	0	0	194.02
194.03	VACANT	0	0	0	0	0	194.03
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	440,976	302,805	3,042,399	473,392	306,499	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151308

Period:
From 07/01/2010
To 06/30/2011

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Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	EMPLOYEE BENEFITS				4.00
5.00	ADMINISTRATIVE & GENERAL				5.00
7.00	OPERATION OF PLANT				7.00
8.00	LAUNDRY & LINEN SERVICE				8.00
9.00	HOUSEKEEPING				9.00
10.00	DIETARY				10.00
11.00	CAFETERIA				11.00
13.00	NURSING ADMINISTRATION				13.00
15.00	PHARMACY				15.00
16.00	MEDICAL RECORDS & LIBRARY				16.00
17.00	SOCIAL SERVICE				17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS	3,997,604	0	3,997,604	30.00
31.00	INTENSIVE CARE UNIT	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	2,126,268	0	2,126,268	50.00
54.00	RADIOLOGY-DIAGNOSTIC	3,845,855	0	3,845,855	54.00
56.00	RADIOISOTOPE	0	0	0	56.00
57.00	CT SCAN	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
60.00	LABORATORY	1,813,430	0	1,813,430	60.00
65.00	RESPIRATORY THERAPY	1,166,576	0	1,166,576	65.00
66.00	PHYSICAL THERAPY	1,160,640	0	1,160,640	66.00
67.00	OCCUPATIONAL THERAPY	38,045	0	38,045	67.00
68.00	SPEECH PATHOLOGY	57,879	0	57,879	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
73.00	DRUGS CHARGED TO PATIENTS	3,106,932	0	3,106,932	73.00
76.00	SLEEP LAB	0	0	0	76.00
76.01	ONCOLOGY	360,183	0	360,183	76.01
76.02	ECLIPSYS	0	0	0	76.02
76.03	WOUND CARE	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS					
90.00	CLINIC	88,147	0	88,147	90.00
91.00	EMERGENCY	4,285,722	0	4,285,722	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)		0		92.00
SPECIAL PURPOSE COST CENTERS					
118.00	SUBTOTALS (SUM OF LINES 1-117)	22,047,281	0	22,047,281	118.00
NONREIMBURSABLE COST CENTERS					
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	11,450	0	11,450	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	52,826	0	52,826	192.00
194.00	MARKETING	425,334	0	425,334	194.00
194.01	FOUNDATION	12,880	0	12,880	194.01
194.02	CLINIC	0	0	0	194.02
194.03	VACANT	23,171	0	23,171	194.03
200.00	Cross Foot Adjustments	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	22,572,942	0	22,572,942	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151308

Period:
From 07/01/2010
To 06/30/2011

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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	EMPLOYEE BENEFITS	0	4,272	298	4,570	4,570
5.00	ADMINISTRATIVE & GENERAL	0	221,279	45,355	266,634	1,068
7.00	OPERATION OF PLANT	0	90,096	24,748	114,844	140
8.00	LAUNDRY & LINEN SERVICE	0	7,109	0	7,109	15
9.00	HOUSEKEEPING	0	4,333	1,767	6,100	114
10.00	DIETARY	0	11,789	5,385	17,174	42
11.00	CAFETERIA	0	7,477	0	7,477	66
13.00	NURSING ADMINISTRATION	0	8,615	2,139	10,754	50
15.00	PHARMACY	0	6,629	34,559	41,188	165
16.00	MEDICAL RECORDS & LIBRARY	0	10,386	0	10,386	73
17.00	SOCIAL SERVICE	0	2,644	3,107	5,751	47
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	0	40,623	56,040	96,663	587
31.00	INTENSIVE CARE UNIT	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	39,883	105,951	145,834	223
54.00	RADIOLOGY-DIAGNOSTIC	0	25,604	432,148	457,752	497
56.00	RADIOISOTOPE	0	0	0	0	0
57.00	CT SCAN	0	0	0	0	0
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
60.00	LABORATORY	0	11,212	9,751	20,963	61
65.00	RESPIRATORY THERAPY	0	12,549	5,513	18,062	199
66.00	PHYSICAL THERAPY	0	26,303	3,016	29,319	195
67.00	OCCUPATIONAL THERAPY	0	929	0	929	3
68.00	SPEECH PATHOLOGY	0	0	0	0	0
69.00	ELECTROCARDIOLOGY	0	0	0	0	0
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
76.00	SLEEP LAB	0	0	0	0	0
76.01	ONCOLOGY	0	1,766	382	2,148	64
76.02	ECLIPSYS	0	0	0	0	0
76.03	WOUND CARE	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	0	7,385	1,745	9,130	7
91.00	EMERGENCY	0	36,832	23,952	60,784	954
92.00	OBSERVATION BEDS (NON-DISTINCT PART)				0	
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	577,715	755,856	1,333,571	4,570
NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,730	0	1,730	0
192.00	PHYSICIANS' PRIVATE OFFICES	0	7,982	0	7,982	0
194.00	MARKETING	0	2,603	0	2,603	0
194.01	FOUNDATION	0	1,587	0	1,587	0
194.02	CLINIC	0	0	0	0	0
194.03	VACANT	0	3,501	0	3,501	0
200.00	Cross Foot Adjustments				0	
201.00	Negative Cost Centers		0	0	0	0
202.00	TOTAL (sum lines 118-201)	0	595,118	755,856	1,350,974	4,570

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151308

Period:
From 07/01/2010
To 06/30/2011

Worksheet B
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Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
	5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 EMPLOYEE BENEFITS						4.00
5.00 ADMINISTRATIVE & GENERAL	267,702					5.00
7.00 OPERATION OF PLANT	17,485	132,469				7.00
8.00 LAUNDRY & LINEN SERVICE	990	3,370	11,484			8.00
9.00 HOUSEKEEPING	6,733	2,054	2,294	17,295		9.00
10.00 DIETARY	1,924	5,588	221	174	25,123	10.00
11.00 CAFETERIA	4,719	3,544	342	0	0	11.00
13.00 NURSING ADMINISTRATION	2,903	4,083	0	125	0	13.00
15.00 PHARMACY	35,105	3,142	0	432	0	15.00
16.00 MEDICAL RECORDS & LIBRARY	4,660	4,923	0	181	0	16.00
17.00 SOCIAL SERVICE	3,271	1,253	0	91	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	33,163	19,257	3,775	5,661	25,123	30.00
31.00 INTENSIVE CARE UNIT	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	19,945	18,905	1,274	2,325	0	50.00
54.00 RADIOLOGY-DIAGNOSTIC	40,406	12,136	892	1,086	0	54.00
56.00 RADIOISOTOPE	0	0	0	0	0	56.00
57.00 CT SCAN	0	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00 LABORATORY	19,172	5,315	130	1,323	0	60.00
65.00 RESPIRATORY THERAPY	11,643	5,948	0	1,142	0	65.00
66.00 PHYSICAL THERAPY	10,681	12,468	560	1,302	0	66.00
67.00 OCCUPATIONAL THERAPY	377	440	0	0	0	67.00
68.00 SPEECH PATHOLOGY	668	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00 DRUGS CHARGED TO PATIENTS	1	0	0	0	0	73.00
76.00 SLEEP LAB	0	0	0	0	0	76.00
76.01 ONCOLOGY	3,778	837	0	320	0	76.01
76.02 ECLIPSYS	0	0	0	0	0	76.02
76.03 WOUND CARE	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS						
90.00 CLINIC	503	3,500	0	97	0	90.00
91.00 EMERGENCY	44,511	17,458	1,996	2,876	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1-117)	262,638	124,221	11,484	17,135	25,123	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	28	820	0	0	0	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	127	3,783	0	0	0	192.00
194.00 MARKETING	4,840	1,234	0	97	0	194.00
194.01 FOUNDATION	13	752	0	63	0	194.01
194.02 CLINIC	0	0	0	0	0	194.02
194.03 VACANT	56	1,659	0	0	0	194.03
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	267,702	132,469	11,484	17,295	25,123	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151308

Period:
From 07/01/2010
To 06/30/2011

Worksheet B
Part II
Date/Time Prepared:
1/26/2012 11:31 am

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		11.00	13.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
7.00	OPERATION OF PLANT						7.00
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING						9.00
10.00	DIETARY						10.00
11.00	CAFETERIA	16,148					11.00
13.00	NURSING ADMINISTRATION	298	18,213				13.00
15.00	PHARMACY	660	838	81,530			15.00
16.00	MEDICAL RECORDS & LIBRARY	705	0	0	20,928		16.00
17.00	SOCIAL SERVICE	312	300	0	0	11,025	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	4,016	5,100	0	941	10,694	30.00
31.00	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	1,299	1,650	0	3,315	0	50.00
54.00	RADIOLOGY-DIAGNOSTIC	2,558	3,249	0	5,841	0	54.00
56.00	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	CT SCAN	0	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	LABORATORY	467	593	0	2,943	0	60.00
65.00	RESPIRATORY THERAPY	1,190	1,511	0	903	0	65.00
66.00	PHYSICAL THERAPY	1,032	1,311	0	842	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	59	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	68	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	81,530	2,847	0	73.00
76.00	SLEEP LAB	0	0	0	0	0	76.00
76.01	ONCOLOGY	337	428	0	202	0	76.01
76.02	ECLIPSYS	0	0	0	0	0	76.02
76.03	WOUND CARE	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS							
90.00	CLINIC	50	64	0	39	0	90.00
91.00	EMERGENCY	3,180	3,169	0	2,928	331	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	16,104	18,213	81,530	20,928	11,025	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	MARKETING	0	0	0	0	0	194.00
194.01	FOUNDATION	44	0	0	0	0	194.01
194.02	CLINIC	0	0	0	0	0	194.02
194.03	VACANT	0	0	0	0	0	194.03
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	16,148	18,213	81,530	20,928	11,025	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 151308	Period: From 07/01/2010 To 06/30/2011	Worksheet B Part II Date/Time Prepared: 1/26/2012 11:31 am
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Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00 NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00 EMPLOYEE BENEFITS				4.00
5.00 ADMINISTRATIVE & GENERAL				5.00
7.00 OPERATION OF PLANT				7.00
8.00 LAUNDRY & LINEN SERVICE				8.00
9.00 HOUSEKEEPING				9.00
10.00 DIETARY				10.00
11.00 CAFETERIA				11.00
13.00 NURSING ADMINISTRATION				13.00
15.00 PHARMACY				15.00
16.00 MEDICAL RECORDS & LIBRARY				16.00
17.00 SOCIAL SERVICE				17.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00 ADULTS & PEDIATRICS	204,980	0	204,980	30.00
31.00 INTENSIVE CARE UNIT	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS				
50.00 OPERATING ROOM	194,770	0	194,770	50.00
54.00 RADIOLOGY-DIAGNOSTIC	524,417	0	524,417	54.00
56.00 RADIOISOTOPE	0	0	0	56.00
57.00 CT SCAN	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
60.00 LABORATORY	50,967	0	50,967	60.00
65.00 RESPIRATORY THERAPY	40,598	0	40,598	65.00
66.00 PHYSICAL THERAPY	57,710	0	57,710	66.00
67.00 OCCUPATIONAL THERAPY	1,808	0	1,808	67.00
68.00 SPEECH PATHOLOGY	736	0	736	68.00
69.00 ELECTROCARDIOLOGY	0	0	0	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
73.00 DRUGS CHARGED TO PATIENTS	84,378	0	84,378	73.00
76.00 SLEEP LAB	0	0	0	76.00
76.01 ONCOLOGY	8,114	0	8,114	76.01
76.02 ECLIPSYS	0	0	0	76.02
76.03 WOUND CARE	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS				
90.00 CLINIC	13,390	0	13,390	90.00
91.00 EMERGENCY	138,187	0	138,187	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)		0		92.00
SPECIAL PURPOSE COST CENTERS				
118.00 SUBTOTALS (SUM OF LINES 1-117)	1,320,055	0	1,320,055	118.00
NONREIMBURSABLE COST CENTERS				
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,578	0	2,578	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	11,892	0	11,892	192.00
194.00 MARKETING	8,774	0	8,774	194.00
194.01 FOUNDATION	2,459	0	2,459	194.01
194.02 CLINIC	0	0	0	194.02
194.03 VACANT	5,216	0	5,216	194.03
200.00 Cross Foot Adjustments	0	0	0	200.00
201.00 Negative Cost Centers	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	1,350,974	0	1,350,974	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151308

Period:
From 07/01/2010
To 06/30/2011

Worksheet B-1

Date/Time Prepared:
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Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DIRECT COST)					
	1.00	2.00	4.00				
GENERAL SERVICE COST CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	116,611					1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP		688,138				2.00
4.00	EMPLOYEE BENEFITS	837	271	10,337,534			4.00
5.00	ADMINISTRATIVE & GENERAL	43,359	41,292	2,417,334	-5,760,661	16,812,281	5.00
7.00	OPERATION OF PLANT	17,654	22,531	317,624	0	1,098,118	7.00
8.00	LAUNDRY & LINEN SERVICE	1,393	0	33,956	0	62,193	8.00
9.00	HOUSEKEEPING	849	1,609	256,882	0	422,819	9.00
10.00	DIETARY	2,310	4,903	94,770	0	120,831	10.00
11.00	CAFETERIA	1,465	0	148,605	0	296,377	11.00
13.00	NURSING ADMINISTRATION	1,688	1,947	112,466	0	182,303	13.00
15.00	PHARMACY	1,299	31,463	374,423	0	2,204,691	15.00
16.00	MEDICAL RECORDS & LIBRARY	2,035	0	166,216	0	292,641	16.00
17.00	SOCIAL SERVICE	518	2,829	106,053	0	205,436	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	7,960	51,019	1,327,578	0	2,082,716	30.00
31.00	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	7,815	96,459	504,147	0	1,252,614	50.00
54.00	RADIOLOGY-DIAGNOSTIC	5,017	393,430	1,123,731	0	2,537,610	54.00
56.00	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	CT SCAN	0	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	LABORATORY	2,197	8,877	136,921	0	1,204,064	60.00
65.00	RESPIRATORY THERAPY	2,459	5,019	449,586	0	731,196	65.00
66.00	PHYSICAL THERAPY	5,154	2,746	442,017	0	670,809	66.00
67.00	OCCUPATIONAL THERAPY	182	0	5,834	0	23,684	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	41,967	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	48	73.00
76.00	SLEEP LAB	0	0	0	0	0	76.00
76.01	ONCOLOGY	346	348	145,688	0	237,269	76.01
76.02	ECLIPSYS	0	0	0	0	0	76.02
76.03	WOUND CARE	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS							
90.00	CLINIC	1,447	1,589	15,078	0	31,579	90.00
91.00	EMERGENCY	7,217	21,806	2,158,625	0	2,795,321	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	113,201	688,138	10,337,534	-5,760,661	16,494,286	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	339	0	0	0	1,730	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	1,564	0	0	0	7,982	192.00
194.00	MARKETING	510	0	0	0	303,980	194.00
194.01	FOUNDATION	311	0	0	0	802	194.01
194.02	CLINIC	0	0	0	0	0	194.02
194.03	VACANT	686	0	0	0	3,501	194.03
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)	595,118	755,856	4,224,794		5,760,661	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	5.103447	1.098408	0.408685		0.342646	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			4,570		267,702	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000442		0.015923	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151308

Period:
From 07/01/2010
To 06/30/2011

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		OPERATION OF PLANT (SQARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (PATIENT DAYS)	CAFETERIA (HOURS)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
7.00	OPERATION OF PLANT	54,761					7.00
8.00	LAUNDRY & LINEN SERVICE	1,393	160,511				8.00
9.00	HOUSEKEEPING	849	32,060	2,484			9.00
10.00	DIETARY	2,310	3,094	25	2,757		10.00
11.00	CAFETERIA	1,465	4,779	0	0	233,120	11.00
13.00	NURSING ADMINISTRATION	1,688	0	18	0	4,300	13.00
15.00	PHARMACY	1,299	0	62	0	9,529	15.00
16.00	MEDICAL RECORDS & LIBRARY	2,035	0	26	0	10,179	16.00
17.00	SOCIAL SERVICE	518	0	13	0	4,506	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	7,960	52,760	813	2,757	57,966	30.00
31.00	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	7,815	17,803	334	0	18,752	50.00
54.00	RADIOLOGY-DIAGNOSTIC	5,017	12,463	156	0	36,934	54.00
56.00	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	CT SCAN	0	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	LABORATORY	2,197	1,815	190	0	6,746	60.00
65.00	RESPIRATORY THERAPY	2,459	0	164	0	17,174	65.00
66.00	PHYSICAL THERAPY	5,154	7,832	187	0	14,899	66.00
67.00	OCCUPATIONAL THERAPY	182	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	SLEEP LAB	0	0	0	0	0	76.00
76.01	ONCOLOGY	346	0	46	0	4,869	76.01
76.02	ECLIPSYS	0	0	0	0	0	76.02
76.03	WOUND CARE	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS							
90.00	CLINIC	1,447	0	14	0	727	90.00
91.00	EMERGENCY	7,217	27,905	413	0	45,903	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	51,351	160,511	2,461	2,757	232,484	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	339	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	1,564	0	0	0	0	192.00
194.00	MARKETING	510	0	14	0	0	194.00
194.01	FOUNDATION	311	0	9	0	636	194.01
194.02	CLINIC	0	0	0	0	0	194.02
194.03	VACANT	686	0	0	0	0	194.03
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)	1,474,384	121,008	614,724	232,947	440,976	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	26.923979	0.753892	247.473430	84.492927	1.891627	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	132,469	11,484	17,295	25,123	16,148	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	2.419039	0.071546	6.962560	9.112441	0.069269	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151308

Period:
From 07/01/2010
To 06/30/2011

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		NURSING ADMINISTRATION (DIRECT NRSING HRS)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (PATIENT REVENUE)	SOCIAL SERVICE (TIME SPENT)	
		13.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	EMPLOYEE BENEFITS					4.00
5.00	ADMINISTRATIVE & GENERAL					5.00
7.00	OPERATION OF PLANT					7.00
8.00	LAUNDRY & LINEN SERVICE					8.00
9.00	HOUSEKEEPING					9.00
10.00	DIETARY					10.00
11.00	CAFETERIA					11.00
13.00	NURSING ADMINISTRATION	207,029				13.00
15.00	PHARMACY	9,529	100			15.00
16.00	MEDICAL RECORDS & LIBRARY	0	0	49,662,151		16.00
17.00	SOCIAL SERVICE	3,407	0	0	4,990	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	57,966	0	2,234,821	4,840	30.00
31.00	INTENSIVE CARE UNIT	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	18,752	0	7,874,810	0	50.00
54.00	RADIOLOGY-DIAGNOSTIC	36,934	0	13,823,578	0	54.00
56.00	RADIOISOTOPE	0	0	0	0	56.00
57.00	CT SCAN	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
60.00	LABORATORY	6,746	0	6,990,123	0	60.00
65.00	RESPIRATORY THERAPY	17,174	0	2,144,495	0	65.00
66.00	PHYSICAL THERAPY	14,899	0	1,999,349	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	141,192	0	67.00
68.00	SPEECH PATHOLOGY	0	0	160,688	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
73.00	DRUGS CHARGED TO PATIENTS	0	100	6,763,404	0	73.00
76.00	SLEEP LAB	0	0	0	0	76.00
76.01	ONCOLOGY	4,869	0	480,812	0	76.01
76.02	ECLIPSYS	0	0	0	0	76.02
76.03	WOUND CARE	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	727	0	92,921	0	90.00
91.00	EMERGENCY	36,026	0	6,955,958	150	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	207,029	100	49,662,151	4,990	118.00
NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00	MARKETING	0	0	0	0	194.00
194.01	FOUNDATION	0	0	0	0	194.01
194.02	CLINIC	0	0	0	0	194.02
194.03	VACANT	0	0	0	0	194.03
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)	302,805	3,042,399	473,392	306,499	202.00
203.00	Unit cost multiplier (wkst. B, Part I)	1.462621	30,423.990000	0.009532	61.422645	203.00
204.00	Cost to be allocated (per wkst. B, Part II)	18,213	81,530	20,928	11,025	204.00
205.00	Unit cost multiplier (wkst. B, Part II)	0.087973	815.300000	0.000421	2.209419	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151308

Period:
From 07/01/2010
To 06/30/2011

Worksheet C
Part I
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Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Hospital		Total Costs	
			Costs			
			Total Costs	RCE Disallowance		
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS					30.00
31.00	INTENSIVE CARE UNIT					31.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM					50.00
54.00	RADIOLOGY-DIAGNOSTIC					54.00
56.00	RADIOISOTOPE					56.00
57.00	CT SCAN					57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)					58.00
60.00	LABORATORY					60.00
65.00	RESPIRATORY THERAPY	0				65.00
66.00	PHYSICAL THERAPY	0				66.00
67.00	OCCUPATIONAL THERAPY	0				67.00
68.00	SPEECH PATHOLOGY	0				68.00
69.00	ELECTROCARDIOLOGY					69.00
70.00	ELECTROENCEPHALOGRAPHY					70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS					71.00
73.00	DRUGS CHARGED TO PATIENTS					73.00
76.00	SLEEP LAB					76.00
76.01	ONCOLOGY					76.01
76.02	ECLIPSYS					76.02
76.03	WOUND CARE					76.03
OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC					90.00
91.00	EMERGENCY					91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
200.00	Subtotal (see instructions)		0			200.00
201.00	Less Observation Beds					201.00
202.00	Total (see instructions)		0			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151308

Period:
From 07/01/2010
To 06/30/2011

Worksheet C
Part I
Date/Time Prepared:
1/26/2012 11:31 am

		Title XVIII			Hospital	Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				
				9.00	10.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	1,910,463		1,910,463			30.00
31.00	INTENSIVE CARE UNIT	0		0			31.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	826,275	7,048,535	7,874,810	0.270009	0.000000	50.00
54.00	RADIOLOGY-DIAGNOSTIC	981,176	12,842,402	13,823,578	0.278210	0.000000	54.00
56.00	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
57.00	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
60.00	LABORATORY	1,011,693	5,978,429	6,990,122	0.259428	0.000000	60.00
65.00	RESPIRATORY THERAPY	1,174,053	970,443	2,144,496	0.543986	0.000000	65.00
66.00	PHYSICAL THERAPY	278,956	1,720,393	1,999,349	0.580509	0.000000	66.00
67.00	OCCUPATIONAL THERAPY	46,543	94,649	141,192	0.269456	0.000000	67.00
68.00	SPEECH PATHOLOGY	43,230	117,458	160,688	0.360195	0.000000	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	71.00
73.00	DRUGS CHARGED TO PATIENTS	1,631,678	5,131,726	6,763,404	0.459374	0.000000	73.00
76.00	SLEEP LAB	0	0	0	0.000000	0.000000	76.00
76.01	ONCOLOGY	9,129	471,683	480,812	0.749114	0.000000	76.01
76.02	ECLIPSYS	0	0	0	0.000000	0.000000	76.02
76.03	WOUND CARE	0	0	0	0.000000	0.000000	76.03
OUTPATIENT SERVICE COST CENTERS							
90.00	CLINIC	3,432	89,489	92,921	0.948623	0.000000	90.00
91.00	EMERGENCY	239,920	6,716,038	6,955,958	0.616122	0.000000	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	17,144	307,213	324,357	1.594792	0.000000	92.00
200.00	Subtotal (see instructions)	8,173,692	41,488,458	49,662,150			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	8,173,692	41,488,458	49,662,150			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 151308	Period: From 07/01/2010 To 06/30/2011	Worksheet C Part I Date/Time Prepared: 1/26/2012 11:31 am
	Title XVIII	Hospital	Cost

Cost Center Description	PPS Inpatient Ratio		
	11.00		
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00 ADULTS & PEDIATRICS			30.00
31.00 INTENSIVE CARE UNIT			31.00
ANCILLARY SERVICE COST CENTERS			
50.00 OPERATING ROOM	0.000000		50.00
54.00 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
56.00 RADIOISOTOPE	0.000000		56.00
57.00 CT SCAN	0.000000		57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
60.00 LABORATORY	0.000000		60.00
65.00 RESPIRATORY THERAPY	0.000000		65.00
66.00 PHYSICAL THERAPY	0.000000		66.00
67.00 OCCUPATIONAL THERAPY	0.000000		67.00
68.00 SPEECH PATHOLOGY	0.000000		68.00
69.00 ELECTROCARDIOLOGY	0.000000		69.00
70.00 ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
73.00 DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00 SLEEP LAB	0.000000		76.00
76.01 ONCOLOGY	0.000000		76.01
76.02 ECLIPSYS	0.000000		76.02
76.03 WOUND CARE	0.000000		76.03
OUTPATIENT SERVICE COST CENTERS			
90.00 CLINIC	0.000000		90.00
91.00 EMERGENCY	0.000000		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
200.00 Subtotal (see instructions)			200.00
201.00 Less observation Beds			201.00
202.00 Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151308

Period:
From 07/01/2010
To 06/30/2011

Worksheet C
Part I
Date/Time Prepared:
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Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Title XIX		Hospital		Cost
			Total Costs	RCE Disallowance	Total Costs	Cost	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	3,997,604		3,997,604	0	0	30.00
31.00	INTENSIVE CARE UNIT	0		0	0	0	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	2,126,268		2,126,268	0	0	50.00
54.00	RADIOLOGY-DIAGNOSTIC	3,845,855		3,845,855	0	0	54.00
56.00	RADIOISOTOPE	0		0	0	0	56.00
57.00	CT SCAN	0		0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
60.00	LABORATORY	1,813,430		1,813,430	0	0	60.00
65.00	RESPIRATORY THERAPY	1,166,576	0	1,166,576	0	0	65.00
66.00	PHYSICAL THERAPY	1,160,640	0	1,160,640	0	0	66.00
67.00	OCCUPATIONAL THERAPY	38,045	0	38,045	0	0	67.00
68.00	SPEECH PATHOLOGY	57,879	0	57,879	0	0	68.00
69.00	ELECTROCARDIOLOGY	0		0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	71.00
73.00	DRUGS CHARGED TO PATIENTS	3,106,932		3,106,932	0	0	73.00
76.00	SLEEP LAB	0		0	0	0	76.00
76.01	ONCOLOGY	360,183		360,183	0	0	76.01
76.02	ECLIPSYS	0		0	0	0	76.02
76.03	WOUND CARE	0		0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS							
90.00	CLINIC	88,147		88,147	0	0	90.00
91.00	EMERGENCY	4,285,722		4,285,722	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	520,077		520,077	0	0	92.00
200.00	Subtotal (see instructions)	22,567,358	0	22,567,358	0	0	200.00
201.00	Less Observation Beds	520,077		520,077	0	0	201.00
202.00	Total (see instructions)	22,047,281	0	22,047,281	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151308

Period:
From 07/01/2010
To 06/30/2011

Worksheet C
Part I
Date/Time Prepared:
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Cost Center Description	Charges			Hospital	Cost	
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	1,910,463		1,910,463			30.00
31.00 INTENSIVE CARE UNIT	0		0			31.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	826,275	7,048,535	7,874,810	0.270009	0.000000	50.00
54.00 RADIOLOGY-DIAGNOSTIC	981,176	12,842,402	13,823,578	0.278210	0.000000	54.00
56.00 RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
57.00 CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
60.00 LABORATORY	1,011,693	5,978,429	6,990,122	0.259428	0.000000	60.00
65.00 RESPIRATORY THERAPY	1,174,053	970,443	2,144,496	0.543986	0.000000	65.00
66.00 PHYSICAL THERAPY	278,956	1,720,393	1,999,349	0.580509	0.000000	66.00
67.00 OCCUPATIONAL THERAPY	46,543	94,649	141,192	0.269456	0.000000	67.00
68.00 SPEECH PATHOLOGY	43,230	117,458	160,688	0.360195	0.000000	68.00
69.00 ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	71.00
73.00 DRUGS CHARGED TO PATIENTS	1,631,678	5,131,726	6,763,404	0.459374	0.000000	73.00
76.00 SLEEP LAB	0	0	0	0.000000	0.000000	76.00
76.01 ONCOLOGY	9,129	471,683	480,812	0.749114	0.000000	76.01
76.02 ECLIPSYS	0	0	0	0.000000	0.000000	76.02
76.03 WOUND CARE	0	0	0	0.000000	0.000000	76.03
OUTPATIENT SERVICE COST CENTERS						
90.00 CLINIC	3,432	89,489	92,921	0.948623	0.000000	90.00
91.00 EMERGENCY	239,920	6,716,038	6,955,958	0.616122	0.000000	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	17,144	307,213	324,357	1.603409	0.000000	92.00
200.00 Subtotal (see instructions)	8,173,692	41,488,458	49,662,150			200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	8,173,692	41,488,458	49,662,150			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151308

Period:
From 07/01/2010
To 06/30/2011

Worksheet C
Part I
Date/Time Prepared:
1/26/2012 11:31 am

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS				30.00
31.00	INTENSIVE CARE UNIT				31.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.000000			50.00
54.00	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
56.00	RADIOISOTOPE	0.000000			56.00
57.00	CT SCAN	0.000000			57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000			58.00
60.00	LABORATORY	0.000000			60.00
65.00	RESPIRATORY THERAPY	0.000000			65.00
66.00	PHYSICAL THERAPY	0.000000			66.00
67.00	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	SPEECH PATHOLOGY	0.000000			68.00
69.00	ELECTROCARDIOLOGY	0.000000			69.00
70.00	ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
73.00	DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.00	SLEEP LAB	0.000000			76.00
76.01	ONCOLOGY	0.000000			76.01
76.02	ECLIPSYS	0.000000			76.02
76.03	WOUND CARE	0.000000			76.03
OUTPATIENT SERVICE COST CENTERS					
90.00	CLINIC	0.000000			90.00
91.00	EMERGENCY	0.000000			91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
200.00	Subtotal (see instructions)				200.00
201.00	Less observation Beds				201.00
202.00	Total (see instructions)				202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 151308

Period:
From 07/01/2010
To 06/30/2011

Worksheet C
Part II
Date/Time Prepared:
1/26/2012 11:31 am

Cost Center Description	Title XIX			Hospital Cost		
	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	2,126,268	194,770	1,931,498	0	0	50.00
54.00 RADIOLOGY-DIAGNOSTIC	3,845,855	524,417	3,321,438	0	0	54.00
56.00 RADIOISOTOPE	0	0	0	0	0	56.00
57.00 CT SCAN	0	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00 LABORATORY	1,813,430	50,967	1,762,463	0	0	60.00
65.00 RESPIRATORY THERAPY	1,166,576	40,598	1,125,978	0	0	65.00
66.00 PHYSICAL THERAPY	1,160,640	57,710	1,102,930	0	0	66.00
67.00 OCCUPATIONAL THERAPY	38,045	1,808	36,237	0	0	67.00
68.00 SPEECH PATHOLOGY	57,879	736	57,143	0	0	68.00
69.00 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00 DRUGS CHARGED TO PATIENTS	3,106,932	84,378	3,022,554	0	0	73.00
76.00 SLEEP LAB	0	0	0	0	0	76.00
76.01 ONCOLOGY	360,183	8,114	352,069	0	0	76.01
76.02 ECLIPSYS	0	0	0	0	0	76.02
76.03 WOUND CARE	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS						
90.00 CLINIC	88,147	13,390	74,757	0	0	90.00
91.00 EMERGENCY	4,285,722	138,187	4,147,535	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	520,077	0	520,077	0	0	92.00
200.00 Subtotal (sum of lines 50 thru 199)	18,569,754	1,115,075	17,454,679	0	0	200.00
201.00 Less Observation Beds	520,077	0	520,077	0	0	201.00
202.00 Total (line 200 minus line 201)	18,049,677	594,998	16,934,602	0	0	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY	Provider CCN: 151308	Period: From 07/01/2010 To 06/30/2011	Worksheet C Part II Date/Time Prepared: 1/26/2012 11:31 am
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Cost Center Description		Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	Cost
		6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	2,126,268	7,874,810	0.270009	50.00
54.00	RADIOLOGY-DIAGNOSTIC	3,845,855	13,823,578	0.278210	54.00
56.00	RADIOISOTOPE	0	0	0.000000	56.00
57.00	CT SCAN	0	0	0.000000	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	58.00
60.00	LABORATORY	1,813,430	6,990,122	0.259428	60.00
65.00	RESPIRATORY THERAPY	1,166,576	2,144,496	0.543986	65.00
66.00	PHYSICAL THERAPY	1,160,640	1,999,349	0.580509	66.00
67.00	OCCUPATIONAL THERAPY	38,045	141,192	0.269456	67.00
68.00	SPEECH PATHOLOGY	57,879	160,688	0.360195	68.00
69.00	ELECTROCARDIOLOGY	0	0	0.000000	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0.000000	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	71.00
73.00	DRUGS CHARGED TO PATIENTS	3,106,932	6,763,404	0.459374	73.00
76.00	SLEEP LAB	0	0	0.000000	76.00
76.01	ONCOLOGY	360,183	480,812	0.749114	76.01
76.02	ECLIPSYS	0	0	0.000000	76.02
76.03	WOUND CARE	0	0	0.000000	76.03
OUTPATIENT SERVICE COST CENTERS					
90.00	CLINIC	88,147	92,921	0.948623	90.00
91.00	EMERGENCY	4,285,722	6,955,958	0.616122	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	520,077	324,357	1.603409	92.00
200.00	Subtotal (sum of lines 50 thru 199)	18,569,754	0		200.00
201.00	Less Observation Beds	520,077	0		201.00
202.00	Total (line 200 minus line 201)	18,049,677	97,413,837		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 151308	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part II Date/Time Prepared: 1/26/2012 11:31 am
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Cost Center Description	Title XVIII Hospital Cost					
	Capital Related Cost (from wkst. B, Part II, col. 26)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	194,770	7,874,810	0.024733	400,120	9,896	50.00
54.00 RADIOLOGY-DIAGNOSTIC	524,417	13,823,578	0.037936	385,252	14,615	54.00
56.00 RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00 CT SCAN	0	0	0.000000	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
60.00 LABORATORY	50,967	6,990,122	0.007291	480,980	3,507	60.00
65.00 RESPIRATORY THERAPY	40,598	2,144,496	0.018931	615,404	11,650	65.00
66.00 PHYSICAL THERAPY	57,710	1,999,349	0.028864	81,778	2,360	66.00
67.00 OCCUPATIONAL THERAPY	1,808	141,192	0.012805	10,514	135	67.00
68.00 SPEECH PATHOLOGY	736	160,688	0.004580	15,546	71	68.00
69.00 ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	0	71.00
73.00 DRUGS CHARGED TO PATIENTS	84,378	6,763,404	0.012476	730,463	9,113	73.00
76.00 SLEEP LAB	0	0	0.000000	0	0	76.00
76.01 ONCOLOGY	8,114	480,812	0.016876	2,279	38	76.01
76.02 ECLIPSYS	0	0	0.000000	0	0	76.02
76.03 WOUND CARE	0	0	0.000000	0	0	76.03
OUTPATIENT SERVICE COST CENTERS						
90.00 CLINIC	13,390	92,921	0.144101	1,572	227	90.00
91.00 EMERGENCY	138,187	6,955,958	0.019866	20,788	413	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	324,357	0.000000	1,115	0	92.00
200.00 Total (lines 50-199)	1,115,075	47,751,687		2,745,811	52,025	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151308

Period:
From 07/01/2010
To 06/30/2011

Worksheet D
Part IV
Date/Time Prepared:
1/26/2012 11:31 am

Cost Center Description	Title XVIII				Hospital	Cost	Total Cost (sum of col 1 through col. 4)
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost			
	1.00	2.00	3.00	4.00		5.00	
ANCILLARY SERVICE COST CENTERS							
50.00 OPERATING ROOM	0	0	0	0		0	50.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	0		0	54.00
56.00 RADIOISOTOPE	0	0	0	0		0	56.00
57.00 CT SCAN	0	0	0	0		0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0		0	58.00
60.00 LABORATORY	0	0	0	0		0	60.00
65.00 RESPIRATORY THERAPY	0	0	0	0		0	65.00
66.00 PHYSICAL THERAPY	0	0	0	0		0	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0		0	67.00
68.00 SPEECH PATHOLOGY	0	0	0	0		0	68.00
69.00 ELECTROCARDIOLOGY	0	0	0	0		0	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0		0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0		0	71.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0		0	73.00
76.00 SLEEP LAB	0	0	0	0		0	76.00
76.01 ONCOLOGY	0	0	0	0		0	76.01
76.02 ECLIPSYS	0	0	0	0		0	76.02
76.03 WOUND CARE	0	0	0	0		0	76.03
OUTPATIENT SERVICE COST CENTERS							
90.00 CLINIC	0	0	0	0		0	90.00
91.00 EMERGENCY	0	0	0	0		0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0		0	92.00
200.00 Total (lines 50-199)	0	0	0	0		0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151308	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part IV Date/Time Prepared: 1/26/2012 11:31 am
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Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Title XVIII		Hospital		
		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 OPERATING ROOM	0	7,874,810	0.000000	0.000000	400,120	50.00
54.00 RADIOLOGY-DIAGNOSTIC	0	13,823,578	0.000000	0.000000	385,252	54.00
56.00 RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
57.00 CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
60.00 LABORATORY	0	6,990,122	0.000000	0.000000	480,980	60.00
65.00 RESPIRATORY THERAPY	0	2,144,496	0.000000	0.000000	615,404	65.00
66.00 PHYSICAL THERAPY	0	1,999,349	0.000000	0.000000	81,778	66.00
67.00 OCCUPATIONAL THERAPY	0	141,192	0.000000	0.000000	10,514	67.00
68.00 SPEECH PATHOLOGY	0	160,688	0.000000	0.000000	15,546	68.00
69.00 ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	71.00
73.00 DRUGS CHARGED TO PATIENTS	0	6,763,404	0.000000	0.000000	730,463	73.00
76.00 SLEEP LAB	0	0	0.000000	0.000000	0	76.00
76.01 ONCOLOGY	0	480,812	0.000000	0.000000	2,279	76.01
76.02 ECLIPSYS	0	0	0.000000	0.000000	0	76.02
76.03 WOUND CARE	0	0	0.000000	0.000000	0	76.03
OUTPATIENT SERVICE COST CENTERS						
90.00 CLINIC	0	92,921	0.000000	0.000000	1,572	90.00
91.00 EMERGENCY	0	6,955,958	0.000000	0.000000	20,788	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	324,357	0.000000	0.000000	1,115	92.00
200.00 Total (lines 50-199)	0	47,751,687			2,745,811	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151308	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part IV Date/Time Prepared: 1/26/2012 11:31 am
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Cost Center Description	Title XVIII			Hospital	Cost	
	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
	11.00	12.00	13.00	21.00	22.00	
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	0	0	0	0	50.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00 RADIOISOTOPE	0	0	0	0	0	56.00
57.00 CT SCAN	0	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00 LABORATORY	0	0	0	0	0	60.00
65.00 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00 SLEEP LAB	0	0	0	0	0	76.00
76.01 ONCOLOGY	0	0	0	0	0	76.01
76.02 ECLIPSYS	0	0	0	0	0	76.02
76.03 WOUND CARE	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS						
90.00 CLINIC	0	0	0	0	0	90.00
91.00 EMERGENCY	0	0	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00 Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151308	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part IV Date/Time Prepared: 1/26/2012 11:31 am
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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	OPERATING ROOM	0	0		50.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00	RADIOISOTOPE	0	0		56.00
57.00	CT SCAN	0	0		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	LABORATORY	0	0		60.00
65.00	RESPIRATORY THERAPY	0	0		65.00
66.00	PHYSICAL THERAPY	0	0		66.00
67.00	OCCUPATIONAL THERAPY	0	0		67.00
68.00	SPEECH PATHOLOGY	0	0		68.00
69.00	ELECTROCARDIOLOGY	0	0		69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
73.00	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	SLEEP LAB	0	0		76.00
76.01	ONCOLOGY	0	0		76.01
76.02	ECLIPSYS	0	0		76.02
76.03	WOUND CARE	0	0		76.03
OUTPATIENT SERVICE COST CENTERS					
90.00	CLINIC	0	0		90.00
91.00	EMERGENCY	0	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00	Total (lines 50-199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151308	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part V Date/Time Prepared: 1/26/2012 11:31 am
Title XVIII		Hospital	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Cost	
		PPS Reimbursed Services (see instructions)	Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)		
	1.00	2.00	3.00	4.00		
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0.270009	0	2,295,513	0	50.00
54.00	RADIOLOGY-DIAGNOSTIC	0.278210	0	3,773,608	90	54.00
56.00	RADIOISOTOPE	0.000000	0	0	0	56.00
57.00	CT SCAN	0.000000	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	58.00
60.00	LABORATORY	0.259428	0	1,884,338	0	60.00
65.00	RESPIRATORY THERAPY	- 0.543986	0	970,443	0	65.00
66.00	PHYSICAL THERAPY	0.580509	0	573,357	0	66.00
67.00	OCCUPATIONAL THERAPY	0.269456	0	21,531	0	67.00
68.00	SPEECH PATHOLOGY	0.360195	0	16,300	0	68.00
69.00	ELECTROCARDIOLOGY	0.000000	0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	71.00
73.00	DRUGS CHARGED TO PATIENTS	0.459374	0	1,451,324	231	73.00
76.00	SLEEP LAB	0.000000	0	0	0	76.00
76.01	ONCOLOGY	0.749114	0	99,715	0	76.01
76.02	ECLIPSYS	0.000000	0	0	0	76.02
76.03	WOUND CARE	0.000000	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	0.948623	0	35,839	0	90.00
91.00	EMERGENCY	0.616122	0	1,612,102	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.594792	0	123,328	0	92.00
200.00	Subtotal (see instructions)		0	12,857,398	321	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		0	12,857,398	321	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151308	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part V Date/Time Prepared: 1/26/2012 11:31 am
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Cost Center Description	Costs			Hospital	Cost
	PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)		
	5.00	6.00	7.00		
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	0	619,809	0		50.00
54.00 RADIOLOGY-DIAGNOSTIC	0	1,049,855	25		54.00
56.00 RADIOISOTOPE	0	0	0		56.00
57.00 CT SCAN	0	0	0		57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
60.00 LABORATORY	0	488,850	0		60.00
65.00 RESPIRATORY THERAPY	0	527,907	0		65.00
66.00 PHYSICAL THERAPY	0	332,839	0		66.00
67.00 OCCUPATIONAL THERAPY	0	5,802	0		67.00
68.00 SPEECH PATHOLOGY	0	5,871	0		68.00
69.00 ELECTROCARDIOLOGY	0	0	0		69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
73.00 DRUGS CHARGED TO PATIENTS	0	666,701	106		73.00
76.00 SLEEP LAB	0	0	0		76.00
76.01 ONCOLOGY	0	74,698	0		76.01
76.02 ECLIPSYS	0	0	0		76.02
76.03 WOUND CARE	0	0	0		76.03
OUTPATIENT SERVICE COST CENTERS					
90.00 CLINIC	0	33,998	0		90.00
91.00 EMERGENCY	0	993,252	0		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	196,683	0		92.00
200.00 Subtotal (see instructions)	0	4,996,265	131		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00 Net Charges (line 200 +/- line 201)	0	4,996,265	131		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151308 Component CCN: 152308	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part V Date/Time Prepared: 1/26/2012 11:31 am
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Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Cost	
		PPS Reimbursed Services (see instructions)	Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)		
		1.00	2.00	3.00		4.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0.270009	0	0	0	50.00
54.00	RADIOLOGY-DIAGNOSTIC	0.278210	0	0	0	54.00
56.00	RADIOISOTOPE	0.000000	0	0	0	56.00
57.00	CT SCAN	0.000000	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	58.00
60.00	LABORATORY	0.259428	0	0	0	60.00
65.00	RESPIRATORY THERAPY	0.543986	0	0	0	65.00
66.00	PHYSICAL THERAPY	0.580509	0	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0.269456	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0.360195	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0.000000	0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	71.00
73.00	DRUGS CHARGED TO PATIENTS	0.459374	0	0	0	73.00
76.00	SLEEP LAB	0.000000	0	0	0	76.00
76.01	ONCOLOGY	0.749114	0	0	0	76.01
76.02	ECLIPSYS	0.000000	0	0	0	76.02
76.03	WOUND CARE	0.000000	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	0.948623	0	0	0	90.00
91.00	EMERGENCY	0.616122	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.594792	0	0	0	92.00
200.00	Subtotal (see instructions)		0	0	0	200.00
201.00	Less PBP Clinic Lab. services-Program Only Charges			0	0	201.00
202.00	Net charges (line 200 +/- line 201)		0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151308 Component CCN: 15Z308	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part V Date/Time Prepared: 1/26/2012 11:31 am
Title XVIII		Swing Beds - SNF	Cost

Cost Center Description	Costs			Swing Beds - SNF	Cost
	PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)		
	5.00	6.00	7.00		
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	0	0	0		50.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
56.00 RADIOISOTOPE	0	0	0		56.00
57.00 CT SCAN	0	0	0		57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
60.00 LABORATORY	0	0	0		60.00
65.00 RESPIRATORY THERAPY	0	0	0		65.00
66.00 PHYSICAL THERAPY	0	0	0		66.00
67.00 OCCUPATIONAL THERAPY	0	0	0		67.00
68.00 SPEECH PATHOLOGY	0	0	0		68.00
69.00 ELECTROCARDIOLOGY	0	0	0		69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00 SLEEP LAB	0	0	0		76.00
76.01 ONCOLOGY	0	0	0		76.01
76.02 ECLIPSYS	0	0	0		76.02
76.03 WOUND CARE	0	0	0		76.03
OUTPATIENT SERVICE COST CENTERS					
90.00 CLINIC	0	0	0		90.00
91.00 EMERGENCY	0	0	0		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00 Subtotal (see instructions)	0	0	0		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00 Net Charges (line 200 +/- line 201)	0	0	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 151308		Period: From 07/01/2010 To 06/30/2011		Worksheet D Part I Date/Time Prepared: 1/26/2012 11:31 am	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	204,980	50,226	154,754	2,240	69.09	30.00
31.00	INTENSIVE CARE UNIT	0		0	0	0.00	31.00
200.00	Total (lines 30-199)	204,980		154,754	2,240		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 151308		Period: From 07/01/2010 To 06/30/2011		Worksheet D Part I Date/Time Prepared: 1/26/2012 11:31 am	
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	Title XIX	Hospital	Cost	
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	144	9,949				30.00
31.00	INTENSIVE CARE UNIT	0	0				31.00
200.00	Total (lines 30-199)	144	9,949				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 151308	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part II Date/Time Prepared: 1/26/2012 11:31 am
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Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Hospital Cost		
				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 OPERATING ROOM	194,770	7,874,810	0.024733	82,070	2,030	50.00
54.00 RADIOLOGY-DIAGNOSTIC	524,417	13,823,578	0.037936	87,164	3,307	54.00
56.00 RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00 CT SCAN	0	0	0.000000	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
60.00 LABORATORY	50,967	6,990,122	0.007291	79,315	578	60.00
65.00 RESPIRATORY THERAPY	40,598	2,144,496	0.018931	74,790	1,416	65.00
66.00 PHYSICAL THERAPY	57,710	1,999,349	0.028864	4,962	143	66.00
67.00 OCCUPATIONAL THERAPY	1,808	141,192	0.012805	1,300	17	67.00
68.00 SPEECH PATHOLOGY	736	160,688	0.004580	2,138	10	68.00
69.00 ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	0	71.00
73.00 DRUGS CHARGED TO PATIENTS	84,378	6,763,404	0.012476	121,547	1,516	73.00
76.00 SLEEP LAB	0	0	0.000000	0	0	76.00
76.01 ONCOLOGY	8,114	480,812	0.016876	0	0	76.01
76.02 ECLIPSYS	0	0	0.000000	0	0	76.02
76.03 WOUND CARE	0	0	0.000000	0	0	76.03
OUTPATIENT SERVICE COST CENTERS						
90.00 CLINIC	13,390	92,921	0.144101	0	0	90.00
91.00 EMERGENCY	138,187	6,955,958	0.019866	70,050	1,392	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	324,357	0.000000	3,960	0	92.00
200.00 Total (lines 50-199)	1,115,075	47,751,687		527,296	10,409	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 151308		Period: From 07/01/2010 To 06/30/2011		Worksheet D Part III Date/Time Prepared: 1/26/2012 11:31 am	
Cost Center Description		Title XIX			Hospital	Cost	
		Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
200.00	Total (lines 30-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 151308		Period: From 07/01/2010 To 06/30/2011		Worksheet D Part III Date/Time Prepared: 1/26/2012 11:31 am	
Cost Center Description		Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. Nursing School Cost	
		6.00	7.00	8.00	9.00	11.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	2,240	0.00	144	0	0	30.00
31.00	INTENSIVE CARE UNIT	0	0.00	0	0	0	31.00
200.00	Total (lines 30-199)	2,240		144	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 151308		Period: From 07/01/2010 To 06/30/2011		Worksheet D Part III Date/Time Prepared: 1/26/2012 11:31 am	
Cost Center Description		PSA Adj. Allied Health Cost 12.00	PSA Adj. All Other Medical Education Cost 13.00	Title XIX	Hospital	Cost	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	0	0				30.00
31.00	INTENSIVE CARE UNIT	0	0				31.00
200.00	Total (lines 30-199)	0	0				200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151308

Period:
From 07/01/2010
To 06/30/2011

Worksheet D
Part IV
Date/Time Prepared:
1/26/2012 11:31 am

Cost Center Description	Title XIX				Hospital	Cost
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	0	0	0	0	50.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00 RADIOISOTOPE	0	0	0	0	0	56.00
57.00 CT SCAN	0	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00 LABORATORY	0	0	0	0	0	60.00
65.00 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00 SLEEP LAB	0	0	0	0	0	76.00
76.01 ONCOLOGY	0	0	0	0	0	76.01
76.02 ECLIPSYS	0	0	0	0	0	76.02
76.03 WOUND CARE	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS						
90.00 CLINIC	0	0	0	0	0	90.00
91.00 EMERGENCY	0	0	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00 Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151308

Period: From 07/01/2010 To 06/30/2011

Worksheet D Part IV Date/Time Prepared: 1/26/2012 11:31 am

Cost Center Description		Title XIX			Hospital		Cost
		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	0	7,874,810	0.000000	0.000000	82,070	50.00
54.00	RADIOLOGY-DIAGNOSTIC	0	13,823,578	0.000000	0.000000	87,164	54.00
56.00	RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
57.00	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
60.00	LABORATORY	0	6,990,122	0.000000	0.000000	79,315	60.00
65.00	RESPIRATORY THERAPY	0	2,144,496	0.000000	0.000000	74,790	65.00
66.00	PHYSICAL THERAPY	0	1,999,349	0.000000	0.000000	4,962	66.00
67.00	OCCUPATIONAL THERAPY	0	141,192	0.000000	0.000000	1,300	67.00
68.00	SPEECH PATHOLOGY	0	160,688	0.000000	0.000000	2,138	68.00
69.00	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	71.00
73.00	DRUGS CHARGED TO PATIENTS	0	6,763,404	0.000000	0.000000	121,547	73.00
76.00	SLEEP LAB	0	0	0.000000	0.000000	0	76.00
76.01	ONCOLOGY	0	480,812	0.000000	0.000000	0	76.01
76.02	ECLIPSYS	0	0	0.000000	0.000000	0	76.02
76.03	WOUND CARE	0	0	0.000000	0.000000	0	76.03
OUTPATIENT SERVICE COST CENTERS							
90.00	CLINIC	0	92,921	0.000000	0.000000	0	90.00
91.00	EMERGENCY	0	6,955,958	0.000000	0.000000	70,050	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	324,357	0.000000	0.000000	3,960	92.00
200.00	Total (lines 50-199)	0	47,751,687			527,296	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151308	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part IV Date/Time Prepared: 1/26/2012 11:31 am
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Cost Center Description	Title XIX			Hospital	Cost	
	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
	11.00	12.00	13.00	21.00	22.00	
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	0	0	0	0	50.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00 RADIOISOTOPE	0	0	0	0	0	56.00
57.00 CT SCAN	0	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00 LABORATORY	0	0	0	0	0	60.00
65.00 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00 SLEEP LAB	0	0	0	0	0	76.00
76.01 ONCOLOGY	0	0	0	0	0	76.01
76.02 ECLIPSYS	0	0	0	0	0	76.02
76.03 WOUND CARE	0	0	0	0	0	76.03
OUTPATIENT SERVICE COST CENTERS						
90.00 CLINIC	0	0	0	0	0	90.00
91.00 EMERGENCY	0	0	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00 Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151308

Period:
From 07/01/2010
To 06/30/2011

Worksheet D
Part IV
Date/Time Prepared:
1/26/2012 11:31 am

Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	Title XIX	Hospital	Cost
		23.00	24.00			
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	0			50.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0			54.00
56.00	RADIOISOTOPE	0	0			56.00
57.00	CT SCAN	0	0			57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0			58.00
60.00	LABORATORY	0	0			60.00
65.00	RESPIRATORY THERAPY	0	0			65.00
66.00	PHYSICAL THERAPY	0	0			66.00
67.00	OCCUPATIONAL THERAPY	0	0			67.00
68.00	SPEECH PATHOLOGY	0	0			68.00
69.00	ELECTROCARDIOLOGY	0	0			69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0			70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			71.00
73.00	DRUGS CHARGED TO PATIENTS	0	0			73.00
76.00	SLEEP LAB	0	0			76.00
76.01	ONCOLOGY	0	0			76.01
76.02	ECLIPSYS	0	0			76.02
76.03	WOUND CARE	0	0			76.03
OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	0	0			90.00
91.00	EMERGENCY	0	0			91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0			92.00
200.00	Total (lines 50-199)	0	0			200.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 151308	Period: From 07/01/2010 To 06/30/2011	Worksheet D-1 Date/Time Prepared: 1/26/2012 11:31 am
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Cost Center Description	Title XVIII	Hospital	Cost	
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,108	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,240	2.00
3.00	Private room days (excluding swing-bed and observation bed days)		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		2,240	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)		727	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)		141	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		1,159	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)		376	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)		351	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		152.53	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		152.53	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,997,604	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)		21,507	25.00
26.00	Total swing-bed cost (see instructions)		995,767	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		3,001,837	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		1,645,351	28.00
29.00	Private room charges (excluding swing-bed charges)		0	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)		1.824436	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)		3,001,837	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,340.11	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,553,187	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)		1,553,187	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151308

Period:
From 07/01/2010
To 06/30/2011

Worksheet D-1

Date/Time Prepared:
1/26/2012 11:31 am

Cost Center Description	Title XVIII			Hospital	Cost	
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)					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)					48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					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)					50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from wkst. D, sum of Parts II and IV)					51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					54.00
55.00	Target amount per discharge					55.00
56.00	Target amount (line 54 x line 55)					56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					57.00
58.00	Bonus payment (see instructions)					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					59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					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)					61.00
62.00	Relief payment (see instructions)					62.00
63.00	Allowable inpatient cost plus incentive payment (see instructions)					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)					64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					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)					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)					68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					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)					87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151308

Period:
From 07/01/2010
To 06/30/2011

Worksheet D-1

Date/Time Prepared:
1/26/2012 11:31 am

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

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 151308	Period: From 07/01/2010 To 06/30/2011	Worksheet D-1 Date/Time Prepared: 1/26/2012 11:31 am
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Cost Center Description	Title XIX	Hospital	Cost	
			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,108	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,240	2.00
3.00	Private room days (excluding swing-bed and observation bed days)		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		2,240	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)		727	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)		141	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		144	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)		3,997,604	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)		979,531	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		3,018,073	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	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)		0.000000	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)		3,018,073	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,347.36	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		194,020	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)		194,020	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 151308	Period: From 07/01/2010 To 06/30/2011	Worksheet D-1 Date/Time Prepared: 1/26/2012 11:31 am
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Cost Center Description	Title XIX			Hospital	Cost
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00 NURSERY (title V & XIX only)					42.00
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	43.00
44.00 CORONARY CARE UNIT					44.00
45.00 BURN INTENSIVE CARE UNIT					45.00
46.00 SURGICAL INTENSIVE CARE UNIT					46.00
47.00 OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description					
					1.00
48.00 Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					217,016 48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					411,036 49.00
PASS THROUGH COST ADJUSTMENTS					
50.00 Pass through costs applicable to Program inpatient routine services (from wkst. D, sum of Parts I and III)					0 50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from wkst. D, sum of Parts II and IV)					0 51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					0 52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0 53.00
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00 Program discharges					0 54.00
55.00 Target amount per discharge					0.00 55.00
56.00 Target amount (line 54 x line 55)					0 56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0 57.00
58.00 Bonus payment (see instructions)					0 58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00 59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00 60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0 61.00
62.00 Relief payment (see instructions)					0 62.00
63.00 Allowable inpatient cost plus incentive payment (see instructions)					0 63.00
PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0 64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0 65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0 66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0 67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0 68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0 69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY					
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)					70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00 Program routine service cost (line 9 x line 71)					72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from worksheet B, Part II, column 26, line 45)					75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00 Program capital-related costs (line 9 x line 76)					77.00
78.00 Inpatient routine service cost (line 74 minus line 77)					78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00 Inpatient routine service cost per diem limitation					81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00 Reasonable inpatient routine service costs (see instructions)					83.00
84.00 Program inpatient ancillary services (see instructions)					84.00
85.00 Utilization review - physician compensation (see instructions)					85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00 Total observation bed days (see instructions)					386 87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,347.35 88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					520,077 89.00

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COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151308

Period:
From 07/01/2010
To 06/30/2011

Worksheet D-1

Date/Time Prepared:
1/26/2012 11:31 am

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 151308	Period: From 07/01/2010 To 06/30/2011	Worksheet D-3 Date/Time Prepared: 1/26/2012 11:31 am
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Cost Center Description		Title XVIII	Hospital	Cost
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS		1,005,207	30.00
31.00	INTENSIVE CARE UNIT		0	31.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0.270009	400,120	50.00
54.00	RADIOLOGY-DIAGNOSTIC	0.278210	385,252	54.00
56.00	RADIOISOTOPE	0.000000	0	56.00
57.00	CT SCAN	0.000000	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	58.00
60.00	LABORATORY	0.259428	480,980	60.00
65.00	RESPIRATORY THERAPY	0.543986	615,404	65.00
66.00	PHYSICAL THERAPY	0.580509	81,778	66.00
67.00	OCCUPATIONAL THERAPY	0.269456	10,514	67.00
68.00	SPEECH PATHOLOGY	0.360195	15,546	68.00
69.00	ELECTROCARDIOLOGY	0.000000	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0.000000	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	71.00
73.00	DRUGS CHARGED TO PATIENTS	0.459374	730,463	73.00
76.00	SLEEP LAB	0.000000	0	76.00
76.01	ONCOLOGY	0.749114	2,279	76.01
76.02	ECLIPSYS	0.000000	0	76.02
76.03	WOUND CARE	0.000000	0	76.03
OUTPATIENT SERVICE COST CENTERS				
90.00	CLINIC	0.948623	1,572	90.00
91.00	EMERGENCY	0.616122	20,788	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.594792	1,115	92.00
200.00	Total (sum of lines 50-94 and 96-98)		2,745,811	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00	Net charges (line 200 minus line 201)		2,745,811	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151308 Component CCN: 152308	Period: From 07/01/2010 To 06/30/2011	Worksheet D-3 Date/Time Prepared: 1/26/2012 11:31 am
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	ADULTS & PEDIATRICS		7,487	30.00
31.00	INTENSIVE CARE UNIT		0	31.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0.270009	56,919	15,369 50.00
54.00	RADIOLOGY-DIAGNOSTIC	0.278210	43,291	12,044 54.00
56.00	RADIOISOTOPE	0.000000	0	0 56.00
57.00	CT SCAN	0.000000	0	0 57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0 58.00
60.00	LABORATORY	0.259428	123,386	32,010 60.00
65.00	RESPIRATORY THERAPY	0.543986	185,451	100,883 65.00
66.00	PHYSICAL THERAPY	0.580509	139,938	81,235 66.00
67.00	OCCUPATIONAL THERAPY	0.269456	25,002	6,737 67.00
68.00	SPEECH PATHOLOGY	0.360195	16,242	5,850 68.00
69.00	ELECTROCARDIOLOGY	0.000000	0	0 69.00
70.00	ELECTROENCEPHALOGRAPHY	0.000000	0	0 70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0 71.00
73.00	DRUGS CHARGED TO PATIENTS	0.459374	274,911	126,287 73.00
76.00	SLEEP LAB	0.000000	0	0 76.00
76.01	ONCOLOGY	0.749114	2,655	1,989 76.01
76.02	ECLIPSYS	0.000000	0	0 76.02
76.03	WOUND CARE	0.000000	0	0 76.03
OUTPATIENT SERVICE COST CENTERS				
90.00	CLINIC	0.948623	1,860	1,764 90.00
91.00	EMERGENCY	0.616122	3,833	2,362 91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.594792	0	0 92.00
200.00	Total (sum of lines 50-94 and 96-98)		873,488	386,530 200.00
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)		873,488	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151308	Period: From 07/01/2010 To 06/30/2011	Worksheet D-3	
		Title XIX		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	ADULTS & PEDIATRICS		123,850		30.00
31.00	INTENSIVE CARE UNIT		0		31.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.270009	82,070	22,160	50.00
54.00	RADIOLOGY-DIAGNOSTIC	0.278210	87,164	24,250	54.00
56.00	RADIOISOTOPE	0.000000	0	0	56.00
57.00	CT SCAN	0.000000	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
60.00	LABORATORY	0.259428	79,315	20,577	60.00
65.00	RESPIRATORY THERAPY	0.543986	74,790	40,685	65.00
66.00	PHYSICAL THERAPY	0.580509	4,962	2,880	66.00
67.00	OCCUPATIONAL THERAPY	0.269456	1,300	350	67.00
68.00	SPEECH PATHOLOGY	0.360195	2,138	770	68.00
69.00	ELECTROCARDIOLOGY	0.000000	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
73.00	DRUGS CHARGED TO PATIENTS	0.459374	121,547	55,836	73.00
76.00	SLEEP LAB	0.000000	0	0	76.00
76.01	ONCOLOGY	0.749114	0	0	76.01
76.02	ECLIPSYS	0.000000	0	0	76.02
76.03	WOUND CARE	0.000000	0	0	76.03
OUTPATIENT SERVICE COST CENTERS					
90.00	CLINIC	0.948623	0	0	90.00
91.00	EMERGENCY	0.616122	70,050	43,159	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.603409	3,960	6,349	92.00
200.00	Total (sum of lines 50-94 and 96-98)		527,296	217,016	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net Charges (line 200 minus line 201)		527,296		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151308	Period: From 07/01/2010 To 06/30/2011	Worksheet E Part B Date/Time Prepared: 1/26/2012 11:31 am
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			4,996,396 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			0 2.00
3.00	PPS payments			0 3.00
4.00	Outlier payment (see instructions)			0 4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000 5.00
6.00	Line 2 times line 5			0 6.00
7.00	Sum of line 3 plus line 4 divided by line 6			0.00 7.00
8.00	Transitional corridor payment (see instructions)			0 8.00
9.00	Ancillary service other pass through costs from worksheet D, Part IV, column 13, line 200			0 9.00
10.00	Organ acquisitions			0 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			4,996,396 11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges			0 12.00
13.00	Organ acquisition charges (from worksheet D-4, Part III, line 69, col. 4)			0 13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0 14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR 413.13(e)			0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000 17.00
18.00	Total customary charges (see instructions)			0 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0 19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0 20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)			5,046,360 21.00
22.00	Interns and residents (see instructions)			0 22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)			0 23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)			0 24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)			40,297 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			2,228,711 26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)			2,777,352 27.00
28.00	Direct graduate medical education payments (from worksheet E-4, line 50)			0 28.00
29.00	ESRD direct medical education costs (from worksheet E-4, line 36)			0 29.00
30.00	Subtotal (sum of lines 27 through 29)			2,777,352 30.00
31.00	Primary payer payments			238 31.00
32.00	Subtotal (line 30 minus line 31)			2,777,114 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)			503,567 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			503,567 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			380,597 36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)			3,280,681 37.00
38.00	MSP-LCC reconciliation amount from PS&R			0 38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0 39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)			3,280,681 40.00
41.00	Interim payments			3,071,213 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)			209,468 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: 151308	Period: From 07/01/2010 To 06/30/2011	Worksheet E Part B Date/Time Prepared: 1/26/2012 11:31 am
	Title XVIII	Hospital	Cost
			Overrides
			1.00
WORKSHEET OVERRIDE VALUES			
112.00	override of Ancillary service charges (line 12)		0 112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 151308		Period: From 07/01/2010 To 06/30/2011		Worksheet E-1 Part I Date/Time Prepared: 1/26/2012 11:31 am	
		Title XVIII		Hospital		Cost	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		2,071,397		2,738,616		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	05/19/2011	42,004	05/19/2011	193,726		3.01
3.02		02/10/2011	1,154	02/10/2011	97,222		3.02
3.03			0	02/10/2011	44,247		3.03
3.04			0		0		3.04
3.05			0		0		3.05
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM	02/10/2011	17,908	02/10/2011	2,598		3.50
3.51		02/10/2011	3,126		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)		22,124		332,597		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)		2,093,521		3,071,213		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		346,049		209,468		6.01
6.02	SETTLEMENT TO PROGRAM		0		0		6.02
7.00	Total Medicare program liability (see instructions)		2,439,570		3,280,681		7.00
				Contractor Number	Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor						8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 151308	Period: From 07/01/2010 To 06/30/2011	Worksheet E-1 Part I Date/Time Prepared: 1/26/2012 11:31 am	
		Title XVIII		Swing Beds - SNF	Cost
		Inpatient Part A		Part B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount
		1.00	2.00	3.00	4.00
1.00	Total interim payments paid to provider		1,117,501		0
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				3.00
Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	02/10/2011	2,436		0
3.02		05/19/2011	208,597		0
3.03			0		0
3.04			0		0
3.05			0		0
Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0
3.51			0		0
3.52			0		0
3.53			0		0
3.54			0		0
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		211,033		0
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to wkst. E or Wkst. E-3, line and column as appropriate)		1,328,534		0
TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				5.00
Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0
5.02			0		0
5.03			0		0
Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0
5.51			0		0
5.52			0		0
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				6.00
6.01	SETTLEMENT TO PROVIDER		31,974		0
6.02	SETTLEMENT TO PROGRAM		0		0
7.00	Total Medicare program liability (see instructions)		1,360,508		0
				Contractor Number	Date (Mo/Day/Yr)
			0	1.00	2.00
8.00	Name of Contractor				8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 151308	Period: From 07/01/2010	Worksheet E-2
	Component CCN: 152308	To 06/30/2011	Date/Time Prepared: 1/26/2012 11:31 am

Title XVIII		Swing Beds - SNF	Cost	
		Part A	Part B	
		1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)	984,003	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, column 3, line 200 for Part A, and sum of Wkst. D, Part V, columns 5 and 7, line 202 for Part B) (For CAH, see instructions)	390,395	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	727	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	1,374,398	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,374,398	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	1,374,398	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	13,890	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	1,360,508	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
17.00	Reimbursable bad debts (see instructions)	0	0	17.00
18.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (sum of lines 15 and 17, plus/minus line 16)	1,360,508	0	19.00
20.00	Interim payments	1,328,534	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus the sum of lines 20 and 21)	31,974	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151308	Period: From 07/01/2010 To 06/30/2011	Worksheet E-3 Part V Date/Time Prepared: 1/26/2012 11:31 am
	Title XVIII	Hospital	Cost

			1.00	
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)				
1.00	Inpatient services		2,637,201	1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction)		0	2.00
3.00	Organ acquisition		0	3.00
4.00	Subtotal (sum of lines 1 thru 3)		2,637,201	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 5 less line 6) . For CAH (see instructions)		2,663,573	6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
7.00	Routine service charges		0	7.00
8.00	Ancillary service charges		0	8.00
9.00	Organ acquisition charges, net of revenue		0	9.00
10.00	Total reasonable charges		0	10.00
Customary charges				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)		0.000000	13.00
14.00	Total customary charges (see instructions)		0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)		0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)		0	16.00
17.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)		0	17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)		0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)		2,663,573	19.00
20.00	Deductibles (exclude professional component)		261,468	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus sum of lines 20 and 21)		2,402,105	22.00
23.00	Coinsurance		1,375	23.00
24.00	Subtotal (line 22 minus line 23)		2,400,730	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		38,840	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		38,840	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		31,658	27.00
28.00	Subtotal (sum of lines 24 and 25 or 26(line 26 hospital and subprovider only))		2,439,570	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	29.00
29.99	Recovery of Accelerated Depreciation		0	29.99
30.00	Subtotal (line 28, plus or minus lines 29)		2,439,570	30.00
31.00	Interim payments		2,093,521	31.00
32.00	Tentative settlement (for contractor use only)		0	32.00
33.00	Balance due provider/program (line 30 minus the sum of lines 31, and 32)		346,049	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151308	Period: From 07/01/2010 To 06/30/2011	Worksheet E-3 Part VII Date/Time Prepared: 1/26/2012 11:31 am
		Title XIX	Hospital	Cost
				1.00
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		411,036	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)		411,036	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)		411,036	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges		0	8.00
9.00	Ancillary service charges		527,296	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)		527,296	12.00
CUSTOMARY CHRGES				
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)		527,296	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 7) (see instructions)		116,260	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 7 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 (line 7)		411,036	21.00
PROSPECTIVE PAYMENT AMOUNT				
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, plus line 3 minus lines 5 and 6)		0	27.00
28.00	Customary charges (title XIX PPS covered services only)		0	28.00
29.00	Titles V or XIX (see instructions)		411,036	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 line 29 minus line 30)		411,036	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)		411,036	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	37.00
38.00	Subtotal (line 36 ± line 37)		411,036	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)		411,036	40.00
41.00	Interim payments		411,036	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: 151308 Period: From 07/01/2010 To 06/30/2011 Worksheet G
 Date/Time Prepared: 1/26/2012 11:31 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	2,279,573	2,398	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	6,891,471	0	0	0	4.00
5.00	Other receivable	836,852	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-4,742,557	0	0	0	6.00
7.00	Inventory	139,438	0	0	0	7.00
8.00	Prepaid expenses	132,470	0	0	0	8.00
9.00	Other current assets	-2,398	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)	5,534,849	2,398	0	0	11.00
FIXED ASSETS						
12.00	Land	457,300	0	0	0	12.00
13.00	Land improvements	537,417	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	27,786,915	0	0	0	15.00
16.00	Accumulated depreciation	-16,304,530	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	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	12,477,102	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	6,025,521	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	34,064	29,861	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	6,059,585	29,861	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	24,071,536	32,259	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	406,178	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,387,438	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	85,309	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	998,581	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2,877,506	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	11,772,983	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	24,971	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	11,797,954	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	14,675,460	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	9,396,076				52.00
53.00	Specific purpose fund		32,259			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	9,396,076	32,259	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	24,071,536	32,259	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151308

Period:
From 07/01/2010
To 06/30/2011

Worksheet G-1

Date/Time Prepared:
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	General Fund		Special Purpose Fund			
	1.00	2.00	3.00	4.00		
	1.00	Fund balances at beginning of period		8,522,828		
2.00	Net income (loss) (from wkst. G-3, line 29)		-59,856			2.00
3.00	Total (sum of line 1 and line 2)		8,462,972		2,313	3.00
4.00	CONTRIBUTIONS AND GRANT	0		96,233		4.00
5.00	OTHER RESTRICTED ACTIVITY	0		643		5.00
6.00	RESTRICTED CONTRIBUTIONS USED FOR PR	42,339		0		6.00
7.00	DEFERRED PENSION COSTS	1,015,628		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		1,057,967		96,876	10.00
11.00	Subtotal (line 3 plus line 10)		9,520,939		99,189	11.00
12.00	NET ASSETS RELEASED FROM RESTRICTION	0		66,929		12.00
13.00	TRANSFERS FROM AFFILIATES	107,261		0		13.00
14.00	OTHER UNRESTRICTED ACTIVITY	17,604		0		14.00
15.00	ROUNDING	2		1		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		124,867		66,930	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		9,396,072		32,259	19.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151308

Period:
From 07/01/2010
To 06/30/2011

Worksheet G-1

Date/Time Prepared:
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	Endowment Fund		Plant Fund		
	5.00	6.00	7.00	8.00	
1.00 Fund balances at beginning of period		0		0	1.00
2.00 Net income (loss) (from wkst. G-3, line 29)					2.00
3.00 Total (sum of line 1 and line 2)		0		0	3.00
4.00 CONTRIBUTIONS AND GRANT	0		0		4.00
5.00 OTHER RESTRICTED ACTIVITY	0		0		5.00
6.00 RESTRICTED CONTRIBUTIONS USED FOR PR	0		0		6.00
7.00 DEFERRED PENSION COSTS	0		0		7.00
8.00	0		0		8.00
9.00	0		0		9.00
10.00 Total additions (sum of line 4-9)		0		0	10.00
11.00 Subtotal (line 3 plus line 10)		0		0	11.00
12.00 NET ASSETS RELEASED FROM RESTRICTION	0		0		12.00
13.00 TRANSFERS FROM AFFILIATES	0		0		13.00
14.00 OTHER UNRESTRICTED ACTIVITY	0		0		14.00
15.00 ROUNDING	0		0		15.00
16.00	0		0		16.00
17.00	0		0		17.00
18.00 Total deductions (sum of lines 12-17)		0		0	18.00
19.00 Fund balance at end of period per balance sheet (line 11 minus line 18)		0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider CCN: 151308	Period: From 07/01/2010 To 06/30/2011	Worksheet G-2 Parts Date/Time Prepared: 1/26/2012 11:31 am
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Cost Center Description	Inpatient	Outpatient	Total	
	1.00	2.00	3.00	
PART I - PATIENT REVENUES				
General Inpatient Routine Services				
1.00 Hospital	1,645,351		1,645,351	1.00
2.00 SUBPROVIDER - IPF				2.00
3.00 SUBPROVIDER - IRF				3.00
4.00 SUBPROVIDER				4.00
5.00 Swing bed - SNF	311,201		311,201	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)	1,956,552		1,956,552	10.00
Intensive Care Type Inpatient Hospital Services				
11.00 INTENSIVE CARE UNIT	0		0	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)	1,956,552		1,956,552	17.00
18.00 Ancillary services	6,360,498	42,420,587	48,781,085	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 PROFESSIONAL FEES	0	3,936,632	3,936,632	27.00
28.00 Total patient revenues (sum of lines 17-27)(transfer column 3 to wkst. G-3, line 1)	8,317,050	46,357,219	54,674,269	28.00
PART II - OPERATING EXPENSES				
29.00 Operating expenses (per wkst. A, column 3, line 200)		23,432,673		29.00
30.00 BAD DEBTS	3,176,193			30.00
31.00	0			31.00
32.00	0			32.00
33.00	0			33.00
34.00	0			34.00
35.00	0			35.00
36.00 Total additions (sum of lines 30-35)		3,176,193		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)		26,608,866		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 151308	Period: From 07/01/2010 To 06/30/2011	Worksheet G-3 Date/Time Prepared: 1/26/2012 11:31 am
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		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	54,674,269	1.00
2.00	Less contractual allowances and discounts on patients' accounts	29,354,162	2.00
3.00	Net patient revenues (line 1 minus line 2)	25,320,107	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	26,608,866	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,288,759	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	551,328	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	75,399	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	30,124	16.00
17.00	Revenue from sale of drugs to other than patients	65,442	17.00
18.00	Revenue from sale of medical records and abstracts	9,869	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	31,696	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISC	54,872	24.00
24.01	NET ASSETS RELEASED	24,590	24.01
24.02	UNREALIZED GAINS/LOSSES	385,083	24.02
24.03	GAIN ON SALE	500	24.03
25.00	Total other income (sum of lines 6-24)	1,228,903	25.00
26.00	Total (line 5 plus line 25)	-59,856	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-59,856	29.00