

**ST. VINCENT RANDOLPH HOSPITAL
WINCHESTER, INDIANA**

**PROVIDER NOS. 15-1301, 15-Z301
AND AIM NO. 100270270A**

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

JUNE 30, 2011

ST. VINCENT RANDOLPH HOSPITAL

PROVIDER NOS. 15-1301, 15-Z301
AND AIM NO. 100270270A

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Accountants' Disclaimer

Hospital Statements of Reimbursable Costs



Board of Directors
St. Vincent Randolph Hospital
Winchester, Indiana

We have compiled the Hospital Statements of Reimbursable Costs (Titles XVIII and XIX) of St. Vincent Randolph Hospital 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 report is intended to be filed with the Centers for Medicare and Medicaid Services and should not be used for any other purposes.

Bradley Associates

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).

FORM APPROVED
OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 151301	Period: From 07/01/2010 To 06/30/2011	Worksheet 5 Parts I-III Date/Time Prepared: 1/30/2012 9:30 am
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PART I - COST REPORT STATUS

Provider use only

1. Electronically filed cost report
 2. Manually submitted cost report
 3. If this is an amended report enter the number of times the provider resubmitted this cost report
 4. Medicare Utilization. Enter "F" for full or "L" for low.

Date: 1/30/2012 Time: 9:30 am

Contractor use only

5. Cost Report Status
 (1) As Submitted
 (2) Settled without Audit
 (3) Settled with Audit
 (4) Reopened
 (5) Amended

6. Date Received:
 7. Contractor No.
 8. Initial Report for this Provider CCN
 9. Final Report for this Provider CCN

10. NPR Date:
 11. Contractor's Vendor Code: 4
 12. If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST. VINCENT RANDOLPH 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: 1/30/2012 Time: 9:30 am
 RAN:mduvBDrKLjwmy6tGyCQI.Cdg:0
 iqxUt0DuyQt767jBGlKymEitp3hg
 hOON0mrL:h0avDmF
 PI: Date: 1/30/2012 Time: 9:30 am
 iAvSEYhB7XQuvnb1zyH.KPNmoxZlW0
 wNxpP0TQstxeCLc7Huer7bh36ZDDq
 qh:5KOKYvD0cMUqW

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

 Title

 Date

	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	174,020	-449,398	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	-7,739	0	0	5.00
6.00	Swing bed - NF	0	0	0	0	6.00
7.00	Skilled Nursing Facility	0	0	0	0	7.00
8.00	Nursing Facility	0	0	0	0	8.00
9.00	HOME HEALTH AGENCY I	0	0	0	0	9.00
10.00	RURAL HEALTH CLINIC I	0	0	0	0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0	0	0	0	11.00
12.00	CMHC I	0	0	0	0	12.00
200.00	Total	0	166,281	-449,398	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: 151301		Period: From 07/01/2010 To 06/30/2011		Worksheet S-2 Part I Date/Time Prepared: 1/26/2012 10:02 am			
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 473 GREENVILLE AVE.			PO Box:				1.00			
2.00	City: WINCHESTER			State: IN		Zip Code: 47934		County: RANDOLPH			
		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	V	XVIII	XIX	
Hospital and Hospital-Based Component Identification:											
3.00	Hospital		ST. VINCENT RANDOLPH HOSPITAL	151301	34620	1	01/01/2000	N	O	O	
4.00	Subprovider - IPF										
5.00	Subprovider - IRF										
6.00	Subprovider - (Other)										
7.00	Swing Beds - SNF		ST. VINCENT RANDOLPH SWING BEDS	152301	34620		09/01/1999	N	O	N	
8.00	Swing Beds - NF							N		N	
9.00	Hospital-Based SNF										
10.00	Hospital-Based NF										
11.00	Hospital-Based OLTC										
12.00	Hospital-Based HHA							N	N	N	
13.00	Separately Certified ASC										
14.00	Hospital-Based Hospice										
15.00	Hospital-Based Health Clinic - RHC										
16.00	Hospital-Based Health Clinic - FQHC										
17.00	Hospital-Based (CMHC) 1										
18.00	Renal Dialysis										
19.00	Other										
							From:	To:			
							1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)						07/01/2010	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.								2		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.								2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.								0		35.00
							Beginning:	Ending:			
							1.00	2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.										36.00

1/26/2012 10:02 am X:\HFSdata\clients\Hospital\St Vincent\Randolph\2540-11.mcrx

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151301	Period: From 07/01/2010 To 06/30/2011	Worksheet S-2 Part I Date/Time Prepared: 1/26/2012 10:02 am		
		Beginning: 1.00	Ending: 2.00			
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0				37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.					38.00
		V	XVIII	XIX		
		1.00	2.00	3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N		45.00
46.00	Is this facility eligible for the special exceptions payment pursuant to 42 CFR Section §412.348(g)? If yes, complete worksheet L, Part III and L-1, Parts I through III	N	N	N		46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N		47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N				56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete worksheet E-4. If column 2 is "N", complete worksheet D, Part III & IV and D-2, Part II, if applicable.	N	N			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	IME Average	Direct GME Average		
		1.00	2.00	3.00		
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)	N	0.00		0.00	61.00
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)		0.00			62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)		0.00			62.01
Teaching Hospitals that Claim Residents in Non-Provider Settings						
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete lines 64-67. (see instructions)	N				63.00
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
		1.00	2.00	3.00		
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. 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	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))
		1.00	2.00	3.00	4.00	5.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151301		Period: From 07/01/2010 To 06/30/2011		Worksheet S-2 Part I Date/Time Prepared: 1/26/2012 10:02 am		
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
		1.00	2.00	3.00	4.00	5.00		
65.00	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		65.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
				1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010								
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000		66.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
		1.00	2.00	3.00	4.00	5.00		
67.00	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		67.00
						1.00	2.00	3.00
Inpatient Psychiatric Facility PPS								
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				N			70.00
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)				N	N	0	71.00
Inpatient Rehabilitation Facility PPS								
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				N			75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)				N	N	0	76.00
							1.00	
Long Term Care Hospital PPS								
80.00	Is this a Long Term Care Hospital (LTCH)? Enter "Y" for yes or "N" for no.						N	80.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151301	Period: From 07/01/2010 To 06/30/2011	Worksheet S-2 Part I Date/Time Prepared: 1/26/2012 10:02 am	
				1.00	
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N	85.00
86.00	Did this facility establish a new other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			N	86.00
		V	XIX		
		1.00	2.00		
Title V or XIX Inpatient Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N		Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N		Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N		N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N		N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.		0.00		95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.		0.00		97.00
Rural Providers					
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?		Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)		N		106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)		N	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	N	N	N
				1.00	2.00
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2.		N		N
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.		N		116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.		Y		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.			2	118.00
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.		250,000		5,000,000
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
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.		Y		121.00
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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 151301	Period: From 07/01/2010 To 06/30/2011	Worksheet S-2 Part I Date/Time Prepared: 1/26/2012 10:02 am				
				1.00	2.00					
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.						134.00			
All Providers										
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)				Y		140.00			
				1.00	2.00	3.00				
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.										
141.00	Name: ST. VINCENT HEALTH		Contractor's Name: NGS		Contractor's Number: 15H046		141.00			
142.00	Street: 10330 N. MERIDIAN ST. SUITE 420		PO Box:				142.00			
143.00	City: INDIANAPOLIS		State:		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.					Y	145.00			
				1.00	2.00					
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.					N	146.00			
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.					N	147.00			
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.					N	148.00			
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.					N	149.00			
				Part A	Part B					
				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	N	161.00			
				1.00						
Multicampus										
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.					N	165.00			
				Name	County	State	Zip Code	CBSA	FTE/Campus	
				0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5								0.00	166.00
				1.00						
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act										
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.					N	167.00			
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						0168.00			
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.00169.00			

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 151301	Period: From 07/01/2010 To 06/30/2011	Worksheet S-2 Part II Date/Time Prepared: 1/26/2012 10:02 am
		Y/N	Date	
		1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N	Date	V/I
		1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "v" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y		3.00
		Y/N	Type	Date
		1.00	2.00	3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
		Y/N	Legal Oper.	
		1.00	2.00	
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N		9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
		Y/N		
		1.00	2.00	
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	12/01/2011	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: 151301	Period: From 07/01/2010 To 06/30/2011	Worksheet S-2 Part II Date/Time Prepared: 1/26/2012 10:02 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	N			29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N			30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N			31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N			32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N			33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y			34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	N			35.00
				Y/N	Date
				1.00	2.00
Home Office Costs					
36.00	Were home office costs claimed on the cost report?	Y			36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y			37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N			38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N			39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N			40.00

		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	12/01/2011	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: 151301

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

Worksheet S-3
Part I
Date/Time Prepared:
1/26/2012 10:02 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	82,560.00	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	82,560.00	7.00
8.00 INTENSIVE CARE UNIT					8.00
9.00 CORONARY CARE UNIT					9.00
10.00 BURN INTENSIVE CARE UNIT					10.00
11.00 SURGICAL INTENSIVE CARE UNIT					11.00
12.00 OTHER SPECIAL CARE (SPECIFY)					12.00
13.00 NURSERY	43.00				13.00
14.00 Total (see instructions)		25	9,125	82,560.00	14.00
15.00 CAH visits					15.00
16.00 SUBPROVIDER - IPF					16.00
17.00 SUBPROVIDER - IRF					17.00
18.00 SUBPROVIDER	42.00	0	0		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	101.00				22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)					23.00
24.00 HOSPICE	116.00	0	0		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
28.03 SUBPROVIDER	42.00				28.03
29.00 Ambulance Trips					29.00
30.00 Employee discount days (see instruction)					30.00
31.00 Employee discount days - IRF					31.00
32.00 Labor & delivery days (see instructions)					32.00
33.00 LTCH non-covered days					33.00

Cost Center Description	I/P Days / O/P Visits / Trips					
	Title V	Title XVIII	Title XIX	Total All Patients		
	5.00	6.00	7.00	8.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, observation Bed and Hospice days)	0	2,024	571	3,440		1.00
2.00 HMO		2	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	427	0	427		5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0		0	109		6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	0	2,451	571	3,976		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	0		283	432		13.00
14.00 Total (see instructions)	0	2,451	854	4,408		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	0	0	0	0		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	0	0	0	0		22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE		0	0	0		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	766		28.00
28.03 SUBPROVIDER	0	0	0	0		28.03
29.00 Ambulance Trips			0			29.00
30.00 Employee discount days (see instruction)				44		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: 151301

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

Worksheet S-3
Part I
Date/Time Prepared:
1/26/2012 10:02 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	573	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	197.00	0.00	0	573	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER	0.00	0.00	0.00	0	0	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	0.00	0.00	0.00			22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	0.00	0.00	0.00			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	197.00	0.00			27.00
28.00 Observation Bed Days						28.00
28.03 SUBPROVIDER						28.03
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

Cost Center Description	Discharges			
	Title XIX	Total All Patients		
	14.00	15.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	232	1,154		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)	232	1,154		14.00
15.00 CAH visits				15.00
16.00 SUBPROVIDER - IPF				16.00
17.00 SUBPROVIDER - IRF				17.00
18.00 SUBPROVIDER	0	0		18.00
19.00 SKILLED NURSING FACILITY				19.00
20.00 NURSING FACILITY				20.00
21.00 OTHER LONG TERM CARE				21.00
22.00 HOME HEALTH AGENCY				22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)				23.00
24.00 HOSPICE				24.00
25.00 CMHC - CMHC				25.00
26.00 RURAL HEALTH CLINIC				26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER				26.25
27.00 Total (sum of lines 14-26)				27.00
28.00 Observation Bed Days				28.00
28.03 SUBPROVIDER				28.03
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: 151301	Period: From 07/01/2010 To 06/30/2011	Worksheet S-10 Date/Time Prepared: 1/26/2012 10:02 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)		0.312819	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		3,789,321	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		1,211,871	5.00
6.00	Medicaid charges		14,455,681	6.00
7.00	Medicaid cost (line 1 times line 6)		4,522,012	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		0	8.00
State Children's Health Insurance Program (SCHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone SCHIP		0	9.00
10.00	Stand-alone SCHIP charges		0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)		0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00
Uncompensated care (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		83,235	18.00
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		0	19.00
		Uninsured patients	Insured patients	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	5,369,980	846	5,370,826
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	1,679,832	265	1,680,097
22.00	Partial payment by patients approved for charity care	0	0	0
23.00	Cost of charity care (line 21 minus line 22)	1,679,832	265	1,680,097
				1.00
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit		0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		4,603,971	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		635,380	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)		3,968,591	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)		1,241,451	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)		2,921,548	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		2,921,548	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151301

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

Worksheet A

Date/Time Prepared:
1/26/2012 10:02 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 CAP REL COSTS-BLDG & FIXT		1,190,450	1,190,450	0	1,190,450	1.00
2.00 CAP REL COSTS-MVBLE EQUIP		473,242	473,242	0	473,242	2.00
3.00 OTHER CAP REL COSTS		0	0	0	0	3.00
4.00 EMPLOYEE BENEFITS	185,809	3,382,960	3,568,769	0	3,568,769	4.00
5.00 ADMINISTRATIVE & GENERAL	2,163,095	1,921,267	4,084,362	800	4,085,162	5.00
6.00 MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00 OPERATION OF PLANT	218,301	963,041	1,181,342	0	1,181,342	7.00
8.00 LAUNDRY & LINEN SERVICE	0	50,592	50,592	0	50,592	8.00
9.00 HOUSEKEEPING	238,985	85,525	324,510	0	324,510	9.00
10.00 DIETARY	288,894	160,233	449,127	-332,371	116,756	10.00
11.00 CAFETERIA	0	0	0	332,371	332,371	11.00
12.00 MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00 NURSING ADMINISTRATION	502,094	27,330	529,424	0	529,424	13.00
14.00 CENTRAL SERVICES & SUPPLY	84,771	29,961	114,732	0	114,732	14.00
15.00 PHARMACY	241,705	749,687	991,392	0	991,392	15.00
16.00 MEDICAL RECORDS & LIBRARY	189,049	50,619	239,668	0	239,668	16.00
17.00 SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	2,411,502	122,106	2,533,608	-369,225	2,164,383	30.00
42.00 SUBPROVIDER	0	0	0	0	0	42.00
43.00 NURSERY	0	21,094	21,094	369,225	390,319	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	469,042	617,132	1,086,174	-255,808	830,366	50.00
51.00 RECOVERY ROOM	0	0	0	0	0	51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 ANESTHESIOLOGY	615,994	117,997	733,991	-800	733,191	53.00
54.00 RADIOLOGY-DIAGNOSTIC	669,577	129,136	798,713	0	798,713	54.00
55.00 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00 RADIOISOTOPE	0	0	0	0	0	56.00
57.00 CT SCAN	35,460	145,847	181,307	0	181,307	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	36,802	261,614	298,416	0	298,416	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 LABORATORY	629,863	1,006,446	1,636,309	0	1,636,309	60.00
64.00 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 RESPIRATORY THERAPY	435,251	39,386	474,637	-113,300	361,337	65.00
65.01 SLEEP LAB	0	50,779	50,779	0	50,779	65.01
66.00 PHYSICAL THERAPY	322,425	21,828	344,253	0	344,253	66.00
67.00 OCCUPATIONAL THERAPY	73,121	3,034	76,155	0	76,155	67.00
68.00 SPEECH PATHOLOGY	11,277	0	11,277	0	11,277	68.00
69.00 ELECTROCARDIOLOGY	26,326	6,444	32,770	113,300	146,070	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	5,260	5,260	0	5,260	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	408,679	408,679	0	408,679	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	256,848	256,848	255,808	512,656	72.00
73.00 DRUGS CHARGED TO PATIENTS	57,633	7,410	65,043	0	65,043	73.00
74.00 RENAL DIALYSIS	0	0	0	0	0	74.00
75.00 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS						
91.00 EMERGENCY	820,800	1,692,231	2,513,031	0	2,513,031	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
116.00 HOSPICE	0	0	0	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	10,727,776	13,998,178	24,725,954	0	24,725,954	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00 RESEARCH	0	0	0	0	0	191.00
192.00 PHYSICIANS' PRIVATE OFFICES	43,679	1,824	45,503	0	45,503	192.00
193.00 NONPAID WORKERS	0	0	0	0	0	193.00
194.00 OTHER NRCC - PUBLIC RELATIONS	0	1,464	1,464	0	1,464	194.00
194.01 OTHER NRCC - FOUNDATION	63,466	93,334	156,800	0	156,800	194.01
194.02 OTHER NRCC - GRANTS	32,594	57,809	90,403	0	90,403	194.02
200.00 TOTAL (SUM OF LINES 118-199)	10,867,515	14,152,609	25,020,124	0	25,020,124	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES	Provider CCN: 151301	Period: From 07/01/2010 To 06/30/2011	Worksheet A Date/Time Prepared: 1/26/2012 10:02 am
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Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation	
	6.00	7.00	
GENERAL SERVICE COST CENTERS			
1.00 CAP REL COSTS-BLDG & FIXT	-261,067	929,383	1.00
2.00 CAP REL COSTS-MVBLE EQUIP	0	473,242	2.00
3.00 OTHER CAP REL COSTS	0	0	3.00
4.00 EMPLOYEE BENEFITS	-185,946	3,382,823	4.00
5.00 ADMINISTRATIVE & GENERAL	370,717	4,455,879	5.00
6.00 MAINTENANCE & REPAIRS	0	0	6.00
7.00 OPERATION OF PLANT	-100	1,181,242	7.00
8.00 LAUNDRY & LINEN SERVICE	0	50,592	8.00
9.00 HOUSEKEEPING	0	324,510	9.00
10.00 DIETARY	-25	116,731	10.00
11.00 CAFETERIA	-102,192	230,179	11.00
12.00 MAINTENANCE OF PERSONNEL	0	0	12.00
13.00 NURSING ADMINISTRATION	0	529,424	13.00
14.00 CENTRAL SERVICES & SUPPLY	-923	113,809	14.00
15.00 PHARMACY	-1,138	990,254	15.00
16.00 MEDICAL RECORDS & LIBRARY	-4,822	234,846	16.00
17.00 SOCIAL SERVICE	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00 ADULTS & PEDIATRICS	-516,368	1,648,015	30.00
42.00 SUBPROVIDER	0	0	42.00
43.00 NURSERY	0	390,319	43.00
ANCILLARY SERVICE COST CENTERS			
50.00 OPERATING ROOM	0	830,366	50.00
51.00 RECOVERY ROOM	0	0	51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00 ANESTHESIOLOGY	-681,007	52,184	53.00
54.00 RADIOLOGY-DIAGNOSTIC	-71,789	726,924	54.00
55.00 RADIOLOGY-THERAPEUTIC	0	0	55.00
56.00 RADIOISOTOPE	0	0	56.00
57.00 CT SCAN	0	181,307	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	298,416	58.00
59.00 CARDIAC CATHETERIZATION	0	0	59.00
60.00 LABORATORY	0	1,636,309	60.00
64.00 INTRAVENOUS THERAPY	0	0	64.00
65.00 RESPIRATORY THERAPY	0	361,337	65.00
65.01 SLEEP LAB	0	50,779	65.01
66.00 PHYSICAL THERAPY	-240	344,013	66.00
67.00 OCCUPATIONAL THERAPY	0	76,155	67.00
68.00 SPEECH PATHOLOGY	0	11,277	68.00
69.00 ELECTROCARDIOLOGY	0	146,070	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	5,260	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	408,679	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	512,656	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	65,043	73.00
74.00 RENAL DIALYSIS	0	0	74.00
75.00 ASC (NON-DISTINCT PART)	0	0	75.00
OUTPATIENT SERVICE COST CENTERS			
91.00 EMERGENCY	-748,191	1,764,840	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)			92.00
OTHER REIMBURSABLE COST CENTERS			
101.00 HOME HEALTH AGENCY	0	0	101.00
SPECIAL PURPOSE COST CENTERS			
116.00 HOSPICE	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	-2,203,091	22,522,863	118.00
NONREIMBURSABLE COST CENTERS			
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
191.00 RESEARCH	0	0	191.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	45,503	192.00
193.00 NONPAID WORKERS	0	0	193.00
194.00 OTHER NRCC - PUBLIC RELATIONS	315,045	316,509	194.00
194.01 OTHER NRCC - FOUNDATION	0	156,800	194.01
194.02 OTHER NRCC - GRANTS	0	90,403	194.02
200.00 TOTAL (SUM OF LINES 118-199)	-1,888,046	23,132,078	200.00

RECLASSIFICATIONS

Provider CCN: 151301

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

Worksheet A-6
Date/Time Prepared:
1/26/2012 10:02 am

		Increases			
Cost Center		Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
A - CAFETERIA					
1.00	CAFETERIA	11.00	213,792	118,579	1.00
	TOTALS		213,792	118,579	
B - EKG					
1.00	ELECTROCARDIOLOGY	69.00	103,898	9,402	1.00
	TOTALS		103,898	9,402	
C - NURSERY RECLASS					
1.00	NURSERY	43.00	351,430	17,795	1.00
	TOTALS		351,430	17,795	
D - DIRECTOR OF ER					
1.00	ADMINISTRATIVE & GENERAL	5.00	800	0	1.00
	TOTALS		800	0	
E - IMPLANTABLE DEVICES					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	255,808	1.00
	TOTALS		0	255,808	
500.00	Grand Total: Increases		669,920	401,584	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	213,792	118,579	0	1.00
	TOTALS		213,792	118,579		
B - EKG						
1.00	RESPIRATORY THERAPY	65.00	103,898	9,402	0	1.00
	TOTALS		103,898	9,402		
C - NURSERY RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	351,430	17,795	0	1.00
	TOTALS		351,430	17,795		
D - DIRECTOR OF ER						
1.00	ANESTHESIOLOGY	53.00	800	0	0	1.00
	TOTALS		800	0		
E - IMPLANTABLE DEVICES						
1.00	OPERATING ROOM	50.00	0	255,808	0	1.00
	TOTALS		0	255,808		
500.00	Grand Total: Decreases		669,920	401,584		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151301

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
1/26/2012 10:02 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	696,652	0	0	0	1.00
2.00	Land Improvements	25,100	0	0	0	2.00
3.00	Buildings and Fixtures	17,950,809	77,903	0	77,903	3.00
4.00	Building Improvements	0	0	0	0	4.00
5.00	Fixed Equipment	450,800	0	0	0	5.00
6.00	Movable Equipment	5,345,372	0	0	0	6.00
7.00	HIT designated Assets	0	0	0	80,349	7.00
8.00	Subtotal (sum of lines 1-7)	24,468,733	77,903	0	77,903	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	24,468,733	77,903	0	77,903	10.00
SUMMARY OF CAPITAL						
Cost Center Description		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)
		9.00	10.00	11.00	12.00	13.00
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,190,450	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	473,242	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,663,692	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	CAP REL COSTS-BLDG & FIXT	0	0	0	1.000000	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1.000000	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151301

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
1/26/2012 10:02 am

		Ending Balance	Fully Depreciated Assets			
		6.00	7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	696,652	0		1.00	
2.00	Land Improvements	25,100	0		2.00	
3.00	Buildings and Fixtures	18,028,712	0		3.00	
4.00	Building Improvements	0	0		4.00	
5.00	Fixed Equipment	450,800	0		5.00	
6.00	Movable Equipment	5,265,023	0		6.00	
7.00	HIT designated Assets	0	0		7.00	
8.00	Subtotal (sum of lines 1-7)	24,466,287	0		8.00	
9.00	Reconciling Items	0	0		9.00	
10.00	Total (line 8 minus line 9)	24,466,287	0		10.00	
SUMMARY OF CAPITAL						
Cost Center Description		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)			
		14.00	15.00			
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	1,190,450		1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	0	473,242		2.00	
3.00	Total (sum of lines 1-2)	0	1,663,692		3.00	
ALLOCATION OF OTHER CAPITAL						
Cost Center Description		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL Depreciation	Lease
		6.00	7.00	8.00	9.00	10.00
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	929,383	0
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	473,242	0
3.00	Total (sum of lines 1-2)	0	0	0	1,402,625	0

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151301

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
1/26/2012 10:02 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	CAP REL COSTS-BLDG & FIXT	0	0	0	0	929,383	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	473,242	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	1,402,625	3.00

		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)			0CAP REL COSTS-BLDG & FIXT	1.00 1.00
2.00	Investment income - movable equipment (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00 2.00
3.00	Investment income - other (chapter 2)		0		0.00 3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00 4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00 5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00 6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00 7.00
8.00	Television and radio service (chapter 21)		0		0.00 8.00
9.00	Parking lot (chapter 21)		0		0.00 9.00
10.00	Provider-based physician adjustment	A-8-2	-2,017,325		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	321,602		12.00
13.00	Laundry and linen service		0		0.00 13.00
14.00	Cafeteria-employees and guests	B	-102,192	CAFETERIA	11.00 14.00
15.00	Rental of quarters to employee and others		0		0.00 15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00 16.00
17.00	Sale of drugs to other than patients		0		0.00 17.00
18.00	Sale of medical records and abstracts		0		0.00 18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00 19.00
20.00	Vending machines		0		0.00 20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00 21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00 22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	0RESPIRATORY THERAPY	65.00 23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	0PHYSICAL 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	0CAP REL COSTS-BLDG & FIXT	1.00 26.00
27.00	Depreciation - movable equipment		0	0CAP 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	0OCCUPATIONAL THERAPY	67.00 30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	0SPEECH PATHOLOGY	68.00 31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00 32.00
33.00			0		0.00 33.00
33.01	OTHER OPERATING INCOME	B	-4,415	ADMINISTRATIVE & GENERAL	5.00 33.01
33.02	OTHER MAINTENANCE INCOME	B	-100	OPERATION OF PLANT	7.00 33.02
33.03	OTHER DIETARY REVENUE	B	-25	DIETARY	10.00 33.03
33.04	OTHER PHARMACY REVENUE	B	-1,138	PHARMACY	15.00 33.04
33.05	OTHER HIM REVENUE	B	-4,822	MEDICAL RECORDS & LIBRARY	16.00 33.05
33.06	OTHER OPERATING REVENUE	B	-923	CENTRAL SERVICES & SUPPLY	14.00 33.06
33.07	OTHER RADIOLOGY REVENUE	B	-30	RADIOLOGY-DIAGNOSTIC	54.00 33.07
33.08	OTHER PHYSICAL THERAPY REVENUE	B	-240	PHYSICAL THERAPY	66.00 33.08
33.09	LOSS ON SALE OF ASSETS	A	-6,073	CAP REL COSTS-BLDG & FIXT	1.00 33.09
33.10	DONATIONS	A	-1,505	ADMINISTRATIVE & GENERAL	5.00 33.10
33.11	AHA & IHA DUES	A	-973	ADMINISTRATIVE & GENERAL	5.00 33.11
33.12	CSI SERVICING FEE	A	37,288	ADMINISTRATIVE & GENERAL	5.00 33.12
33.13	PAVILION DEPRECIATION	A	-2,507	CAP REL COSTS-BLDG & FIXT	1.00 33.13
33.14	CARRYFORWARD	A	-104,668	CAP REL COSTS-BLDG & FIXT	1.00 33.14
33.15			0		0.00 33.15
33.16			0		0.00 33.16
33.17			0		0.00 33.17
33.18			0		0.00 33.18
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200.)		-1,888,046		50.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 151301

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

Worksheet A-8

Date/Time Prepared:
1/26/2012 10:02 am

		Wkst. A-7 Ref.	
		5.00	
1.00	Investment income - buildings and fixtures (chapter 2)	0	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)	0	23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	0	24.00
25.00	utilization review - physicians' compensation (chapter 21)	0	25.00
26.00	Depreciation - buildings and fixtures	0	26.00
27.00	Depreciation - movable equipment	0	27.00
28.00	Non-physician Anesthetist	0	28.00
29.00	Physicians' assistant	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	0	30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	0	31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	0	32.00
33.00		0	33.00
33.01	OTHER OPERATING INCOME	0	33.01
33.02	OTHER MAINTENANCE INCOME	0	33.02
33.03	OTHER DIETARY REVENUE	0	33.03
33.04	OTHER PHARMACY REVENUE	0	33.04
33.05	OTHER HIM REVENUE	0	33.05
33.06	OTHER OPERATING REVENUE	0	33.06
33.07	OTHER RADIOLOGY REVENUE	0	33.07
33.08	OTHER PHYSICAL THERAPY REVENUE	0	33.08
33.09	LOSS ON SALE OF ASSETS	9	33.09
33.10	DONATIONS	0	33.10
33.11	AHA & IHA DUES	0	33.11
33.12	CSI SERVICING FEE	0	33.12
33.13	PAVILION DEPRECIATION	9	33.13
33.14	CARRYFORWARD	9	33.14
33.15		0	33.15
33.16		0	33.16
33.17		0	33.17
33.18		0	33.18
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: 151301

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

Worksheet A-8-1

Date/Time Prepared:
1/26/2012 10:02 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	CAP REL COSTS-BLDG & FIXT	HOME OFFICE	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	2.00
3.00	194.00	OTHER NRCC - PUBLIC RELATIONS	HOME OFFICE	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	ASCENSION INTEREST	4.00
4.01	1.00	CAP REL COSTS-BLDG & FIXT	ASCENSION INTEREST	4.01
4.02	5.00	ADMINISTRATIVE & GENERAL	ASCENSION MAINTENANCE	4.02
4.03	5.00	ADMINISTRATIVE & GENERAL	ST. VINCENT HLTH CHARGEBACK	4.03
4.04	9.00	HOUSEKEEPING	ST. VINCENT HLTH CHARGEBACK	4.04
4.05	14.00	CENTRAL SERVICES & SUPPLY	ST. VINCENT HLTH CHARGEBACK	4.05
4.06	15.00	PHARMACY	ST. VINCENT HLTH CHARGEBACK	4.06
4.07	16.00	MEDICAL RECORDS & LIBRARY	ST. VINCENT HLTH CHARGEBACK	4.07
4.08	54.00	RADIOLOGY-DIAGNOSTIC	ST. VINCENT HLTH CHARGEBACK	4.08
4.09	4.00	EMPLOYEE BENEFITS	ST. VINCENT HLTH CHARGEBACK	4.09
4.10	4.00	EMPLOYEE BENEFITS	ST. VINCENT HLTH CHARGEBACK	4.10
4.11	5.00	ADMINISTRATIVE & GENERAL	ST. VINCENT HLTH CHARGEBACK	4.11
4.12	9.00	HOUSEKEEPING	ST. VINCENT HLTH CHARGEBACK	4.12
4.13	15.00	PHARMACY	ST. VINCENT HLTH CHARGEBACK	4.13
4.14	16.00	MEDICAL RECORDS & LIBRARY	ST. VINCENT HLTH CHARGEBACK	4.14
4.15	30.00	ADULTS & PEDIATRICS	ST. VINCENT HLTH CHARGEBACK	4.15
4.16	53.00	ANESTHESIOLOGY	ST. VINCENT HLTH CHARGEBACK	4.16
4.17	71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	ST. VINCENT HLTH CHARGEBACK	4.17
4.18	91.00	EMERGENCY	ST. VINCENT HLTH CHARGEBACK	4.18
4.19	4.00	EMPLOYEE BENEFITS	SELF INSURANCE	4.19
4.20	4.00	EMPLOYEE BENEFITS	PENSION - NEED TO UPDATE	4.20
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 HTH	100.00	6.00
7.00	B	ASCENSION	100.00	7.00
8.00	B	ST. VINCENT HSP	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
		HOME OFFICE		

(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	264,632	0	264,632	9	1.00
2.00	2,167,407	1,653,406	514,001	9	2.00
3.00	315,045	0	315,045	9	3.00
4.00	0	152,599	-152,599	0	4.00
4.01	0	412,451	-412,451	9	4.01
4.02	281,792	302,872	-21,080	0	4.02
4.03	643,832	643,832	0	0	4.03
4.04	-43,121	-43,121	0	0	4.04
4.05	16,236	16,236	0	0	4.05
4.06	3,564	3,564	0	0	4.06
4.07	36,667	36,667	0	0	4.07
4.08	5,645	5,645	0	0	4.08
4.09	282,067	282,067	0	0	4.09
4.10	45	45	0	0	4.10
4.11	222,865	222,865	0	0	4.11
4.12	-7,409	-7,409	0	0	4.12
4.13	-136,628	-136,628	0	0	4.13
4.14	31,923	31,923	0	0	4.14
4.15	7,108	7,108	0	0	4.15
4.16	5,869	5,869	0	0	4.16
4.17	1,836	1,836	0	0	4.17
4.18	45,761	45,761	0	0	4.18
4.19	977,010	1,162,956	-185,946	0	4.19
4.20	660,576	660,576	0	0	4.20
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to worksheet A-8, column 2, line 12.	5,782,722	5,461,120	321,602	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 HTH	100.00	ADMINISTRATION	6.00
7.00	ASCENSION	100.00	ADMINISTRATION	7.00
8.00	ST. VINCENT HSP	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: 151301

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

Worksheet A-8-2

Date/Time Prepared:
1/26/2012 10:02 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
1.00	30.00	HOSPITALISTS	535,985	516,368	1.00
2.00	53.00	ANESTHESIA	722,171	681,007	2.00
3.00	54.00	RADIOLOGY	71,759	71,759	3.00
4.00	60.00	LABORATORY	30,000	0	4.00
5.00	91.00	ER	1,549,050	748,191	5.00
6.00	0.00		0	0	6.00
7.00	0.00		0	0	7.00
8.00	0.00		0	0	8.00
9.00	0.00		0	0	9.00
10.00	0.00		0	0	10.00
200.00		TOTAL (lines 1.00 through 199.00)	2,908,965	2,017,325	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151301

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

Worksheet A-8-2

Date/Time Prepared:
1/26/2012 10:02 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	19,617	0	0	0	0	1.00
2.00	41,164	0	0	0	0	2.00
3.00	0	0	0	0	0	3.00
4.00	30,000	0	0	0	0	4.00
5.00	800,859	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	891,640					200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151301

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

Worksheet A-8-2

Date/Time Prepared:
1/26/2012 10:02 am

	Cost of Memberships & Continuing Education 12.00	Provider Component Share of col. 13.00	Physician Cost of Malpractice Insurance 14.00	Provider Component Share of col. 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: 151301

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

Worksheet A-8-2

Date/Time Prepared:
1/26/2012 10:02 am

	RCE Disallowance	Adjustment	
	17.00	18.00	
1.00	0	516,368	1.00
2.00	0	681,007	2.00
3.00	0	71,759	3.00
4.00	0	0	4.00
5.00	0	748,191	5.00
6.00	0	0	6.00
7.00	0	0	7.00
8.00	0	0	8.00
9.00	0	0	9.00
10.00	0	0	10.00
200.00	0	2,017,325	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151301

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

Worksheet B
Part I
Date/Time Prepared:
1/26/2012 10:02 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
		1.00	2.00			
	0			4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	929,383	929,383			1.00
2.00	CAP REL COSTS-MVBLE EQUIP	473,242		473,242		2.00
4.00	EMPLOYEE BENEFITS	3,382,823	0	0	3,382,823	4.00
5.00	ADMINISTRATIVE & GENERAL	4,455,879	146,200	74,445	736,500	5,413,024
6.00	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	OPERATION OF PLANT	1,181,242	55,533	28,277	73,359	1,338,411
8.00	LAUNDRY & LINEN SERVICE	50,592	7,581	3,860	0	62,033
9.00	HOUSEKEEPING	324,510	7,107	3,619	80,310	415,546
10.00	DIETARY	116,731	26,369	13,427	25,238	181,765
11.00	CAFETERIA	230,179	6,207	3,161	71,844	311,391
12.00	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	NURSING ADMINISTRATION	529,424	1,706	869	168,727	700,726
14.00	CENTRAL SERVICES & SUPPLY	113,809	0	0	28,487	142,296
15.00	PHARMACY	990,254	0	0	81,224	1,071,478
16.00	MEDICAL RECORDS & LIBRARY	234,846	17,567	8,945	63,529	324,887
17.00	SOCIAL SERVICE	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,648,015	124,795	63,546	692,281	2,528,637
42.00	SUBPROVIDER	0	0	0	0	42.00
43.00	NURSERY	390,319	1,481	754	118,097	510,651
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	830,366	91,509	46,596	157,620	1,126,091
51.00	RECOVERY ROOM	0	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	27,826	14,169	0	41,995
53.00	ANESTHESIOLOGY	52,184	0	0	0	52,184
54.00	RADIOLOGY-DIAGNOSTIC	726,924	73,716	37,536	225,009	1,063,185
55.00	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
56.00	RADIOISOTOPE	0	0	0	0	56.00
57.00	CT SCAN	181,307	0	0	11,916	193,223
58.00	MAGNETIC RESONANCE IMAGING (MRI)	298,416	0	0	12,367	310,783
59.00	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	LABORATORY	1,636,309	20,647	10,514	211,664	1,879,134
64.00	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	361,337	15,032	7,654	111,350	495,373
65.01	SLEEP LAB	50,779	806	410	0	51,995
66.00	PHYSICAL THERAPY	344,013	31,841	16,214	108,350	500,418
67.00	OCCUPATIONAL THERAPY	76,155	3,755	1,912	24,572	106,394
68.00	SPEECH PATHOLOGY	11,277	3,755	1,912	3,790	20,734
69.00	ELECTROCARDIOLOGY	146,070	0	0	43,761	189,831
70.00	ELECTROENCEPHALOGRAPHY	5,260	0	0	0	5,260
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	408,679	19,936	10,152	0	438,767
72.00	IMPL. DEV. CHARGED TO PATIENTS	512,656	0	0	0	512,656
73.00	DRUGS CHARGED TO PATIENTS	65,043	8,671	4,415	19,367	97,496
74.00	RENAL DIALYSIS	0	0	0	0	74.00
75.00	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS						
91.00	EMERGENCY	1,764,840	50,333	25,629	266,502	2,107,304
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
116.00	HOSPICE	0	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	22,522,863	742,373	378,016	3,335,864	22,193,668
NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,516	772	0	2,288
191.00	RESEARCH	0	0	0	0	191.00
192.00	PHYSICIANS' PRIVATE OFFICES	45,503	183,930	93,658	14,678	337,769
193.00	NONPAID WORKERS	0	0	0	0	193.00
194.00	OTHER NRCC - PUBLIC RELATIONS	316,509	782	398	10,953	328,642
194.01	OTHER NRCC - FOUNDATION	156,800	782	398	21,328	179,308
194.02	OTHER NRCC - GRANTS	90,403	0	0	0	90,403
200.00	Cross Foot Adjustments					0
201.00	Negative Cost Centers		0	0	0	0
202.00	TOTAL (sum lines 118-201)	23,132,078	929,383	473,242	3,382,823	23,132,078

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151301

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

Worksheet B
Part I
Date/Time Prepared:
1/26/2012 10:02 am

Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
	5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS						
1.00 CAP REL COSTS-BLDG & FIXT						1.00
2.00 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 EMPLOYEE BENEFITS						4.00
5.00 ADMINISTRATIVE & GENERAL	5,413,024					5.00
6.00 MAINTENANCE & REPAIRS	0	0				6.00
7.00 OPERATION OF PLANT	408,874	0	1,747,285			7.00
8.00 LAUNDRY & LINEN SERVICE	18,951	0	18,205	99,189		8.00
9.00 HOUSEKEEPING	126,946	0	17,067	0	559,559	9.00
10.00 DIETARY	55,528	0	63,318	0	20,695	10.00
11.00 CAFETERIA	95,127	0	14,905	0	4,872	11.00
12.00 MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00 NURSING ADMINISTRATION	214,066	0	4,096	0	1,339	13.00
14.00 CENTRAL SERVICES & SUPPLY	43,470	0	0	0	0	14.00
15.00 PHARMACY	327,328	0	0	0	0	15.00
16.00 MEDICAL RECORDS & LIBRARY	99,250	0	42,184	0	13,787	16.00
17.00 SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	772,472	0	299,667	42,166	97,944	30.00
42.00 SUBPROVIDER	0	0	0	0	0	42.00
43.00 NURSERY	156,000	0	3,556	0	1,162	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	344,012	0	219,737	13,335	71,819	50.00
51.00 RECOVERY ROOM	0	0	0	0	0	51.00
52.00 DELIVERY ROOM & LABOR ROOM	12,829	0	66,817	0	21,839	52.00
53.00 ANESTHESIOLOGY	15,942	0	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	324,795	0	177,013	8,656	57,855	54.00
55.00 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00 RADIOISOTOPE	0	0	0	0	0	56.00
57.00 CT SCAN	59,028	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	94,942	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 LABORATORY	574,060	0	49,579	0	16,205	60.00
64.00 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 RESPIRATORY THERAPY	151,332	0	36,097	0	11,798	65.00
65.01 SLEEP LAB	15,884	0	1,934	0	632	65.01
66.00 PHYSICAL THERAPY	152,874	0	76,460	0	24,990	66.00
67.00 OCCUPATIONAL THERAPY	32,503	0	9,017	0	2,947	67.00
68.00 SPEECH PATHOLOGY	6,334	0	9,017	0	2,947	68.00
69.00 ELECTROCARDIOLOGY	57,992	0	0	0	0	69.00
70.00 ELECTROENCEPHALOGRAPHY	1,607	0	0	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	134,040	0	47,873	0	15,647	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	156,612	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	29,784	0	20,822	0	6,805	73.00
74.00 RENAL DIALYSIS	0	0	0	0	0	74.00
75.00 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS						
91.00 EMERGENCY	643,765	0	120,862	35,032	39,503	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
116.00 HOSPICE	0	0	0	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	5,126,347	0	1,298,226	99,189	412,786	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	699	0	3,641	0	1,190	190.00
191.00 RESEARCH	0	0	0	0	0	191.00
192.00 PHYSICIANS' PRIVATE OFFICES	103,186	0	441,664	0	144,355	192.00
193.00 NONPAID WORKERS	0	0	0	0	0	193.00
194.00 OTHER NRCC - PUBLIC RELATIONS	100,398	0	1,877	0	614	194.00
194.01 OTHER NRCC - FOUNDATION	54,777	0	1,877	0	614	194.01
194.02 OTHER NRCC - GRANTS	27,617	0	0	0	0	194.02
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)	5,413,024	0	1,747,285	99,189	559,559	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151301

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

Worksheet B
Part I
Date/Time Prepared:
1/26/2012 10:02 am

Cost Center Description		DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
		10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
6.00	MAINTENANCE & REPAIRS						6.00
7.00	OPERATION OF PLANT						7.00
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING						9.00
10.00	DIETARY	321,306					10.00
11.00	CAFETERIA	0	426,295				11.00
12.00	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	NURSING ADMINISTRATION	0	8,934	0	929,161		13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	0	0	185,766	14.00
15.00	PHARMACY	0	0	0	0	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	0	22,972	0	0	0	16.00
17.00	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	321,306	105,625	0	523,284	0	30.00
42.00	SUBPROVIDER	0	0	0	0	0	42.00
43.00	NURSERY	0	18,018	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	0	25,953	0	128,576	0	50.00
51.00	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	40,124	0	0	0	54.00
55.00	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
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
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	0	58,873	0	0	0	60.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	0	20,082	0	0	0	65.00
65.01	SLEEP LAB	0	0	0	0	0	65.01
66.00	PHYSICAL THERAPY	0	18,544	0	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	6,888	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	431	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	7,879	0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	8,361	0	0	82,401	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	103,365	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	9,212	0	0	0	73.00
74.00	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS							
91.00	EMERGENCY	0	51,062	0	252,968	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
116.00	HOSPICE	0	0	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	321,306	402,958	0	904,828	185,766	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	RESEARCH	0	0	0	0	0	191.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	4,912	0	24,333	0	192.00
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	OTHER NRCC - PUBLIC RELATIONS	0	11,918	0	0	0	194.00
194.01	OTHER NRCC - FOUNDATION	0	3,408	0	0	0	194.01
194.02	OTHER NRCC - GRANTS	0	3,099	0	0	0	194.02
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)	321,306	426,295	0	929,161	185,766	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151301

Period:
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To 06/30/2011

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Cost Center Description		PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		15.00	16.00	17.00	24.00	25.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
6.00	MAINTENANCE & REPAIRS						6.00
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
12.00	MAINTENANCE OF PERSONNEL						12.00
13.00	NURSING ADMINISTRATION						13.00
14.00	CENTRAL SERVICES & SUPPLY						14.00
15.00	PHARMACY	1,398,806					15.00
16.00	MEDICAL RECORDS & LIBRARY	0	503,080				16.00
17.00	SOCIAL SERVICE	0	0	0			17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	0	36,491	0	4,727,592	0	30.00
42.00	SUBPROVIDER	0	0	0	0	0	42.00
43.00	NURSERY	0	4,076	0	693,463	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	0	54,072	0	1,983,595	0	50.00
51.00	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	1,351	0	144,831	0	52.00
53.00	ANESTHESIOLOGY	0	4,344	0	72,470	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	46,132	0	1,717,760	0	54.00
55.00	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	CT SCAN	0	59,213	0	311,464	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	18,929	0	424,654	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	0	107,633	0	2,685,484	0	60.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	0	11,104	0	725,786	0	65.00
65.01	SLEEP LAB	0	2,719	0	73,164	0	65.01
66.00	PHYSICAL THERAPY	0	15,321	0	788,607	0	66.00
67.00	OCCUPATIONAL THERAPY	0	2,951	0	160,700	0	67.00
68.00	SPEECH PATHOLOGY	0	183	0	39,646	0	68.00
69.00	ELECTROCARDIOLOGY	0	7,806	0	263,508	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	908	0	7,775	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	19,731	0	746,820	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	4,585	0	777,218	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	1,398,806	42,117	0	1,605,042	0	73.00
74.00	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS							
91.00	EMERGENCY	0	63,414	0	3,313,910	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
116.00	HOSPICE	0	0	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	1,398,806	503,080	0	21,263,489	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	7,818	0	190.00
191.00	RESEARCH	0	0	0	0	0	191.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	1,056,219	0	192.00
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	OTHER NRCC - PUBLIC RELATIONS	0	0	0	443,449	0	194.00
194.01	OTHER NRCC - FOUNDATION	0	0	0	239,984	0	194.01
194.02	OTHER NRCC - GRANTS	0	0	0	121,119	0	194.02
200.00	Cross Foot Adjustments	0	0	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	1,398,806	503,080	0	23,132,078	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151301

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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	CAP REL COSTS-BLDG & FIXT		1.00
2.00	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	EMPLOYEE BENEFITS		4.00
5.00	ADMINISTRATIVE & GENERAL		5.00
6.00	MAINTENANCE & REPAIRS		6.00
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
12.00	MAINTENANCE OF PERSONNEL		12.00
13.00	NURSING ADMINISTRATION		13.00
14.00	CENTRAL SERVICES & SUPPLY		14.00
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	4,727,592	30.00
42.00	SUBPROVIDER	0	42.00
43.00	NURSERY	693,463	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	OPERATING ROOM	1,983,595	50.00
51.00	RECOVERY ROOM	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	144,831	52.00
53.00	ANESTHESIOLOGY	72,470	53.00
54.00	RADIOLOGY-DIAGNOSTIC	1,717,760	54.00
55.00	RADIOLOGY-THERAPEUTIC	0	55.00
56.00	RADIOISOTOPE	0	56.00
57.00	CT SCAN	311,464	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	424,654	58.00
59.00	CARDIAC CATHETERIZATION	0	59.00
60.00	LABORATORY	2,685,484	60.00
64.00	INTRAVENOUS THERAPY	0	64.00
65.00	RESPIRATORY THERAPY	725,786	65.00
65.01	SLEEP LAB	73,164	65.01
66.00	PHYSICAL THERAPY	788,607	66.00
67.00	OCCUPATIONAL THERAPY	160,700	67.00
68.00	SPEECH PATHOLOGY	39,646	68.00
69.00	ELECTROCARDIOLOGY	263,508	69.00
70.00	ELECTROENCEPHALOGRAPHY	7,775	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	746,820	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	777,218	72.00
73.00	DRUGS CHARGED TO PATIENTS	1,605,042	73.00
74.00	RENAL DIALYSIS	0	74.00
75.00	ASC (NON-DISTINCT PART)	0	75.00
OUTPATIENT SERVICE COST CENTERS			
91.00	EMERGENCY	3,313,910	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)		92.00
OTHER REIMBURSABLE COST CENTERS			
101.00	HOME HEALTH AGENCY	0	101.00
SPECIAL PURPOSE COST CENTERS			
116.00	HOSPICE	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	21,263,489	118.00
NONREIMBURSABLE COST CENTERS			
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	7,818	190.00
191.00	RESEARCH	0	191.00
192.00	PHYSICIANS' PRIVATE OFFICES	1,056,219	192.00
193.00	NONPAID WORKERS	0	193.00
194.00	OTHER NRCC - PUBLIC RELATIONS	443,449	194.00
194.01	OTHER NRCC - FOUNDATION	239,984	194.01
194.02	OTHER NRCC - GRANTS	121,119	194.02
200.00	Cross Foot Adjustments	0	200.00
201.00	Negative Cost Centers	0	201.00
202.00	TOTAL (sum lines 118-201)	23,132,078	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151301

Period: 07/01/2010
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Cost Center Description	CAPITAL RELATED COSTS			Subtotal	EMPLOYEE BENEFITS	
	Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
				2A	4.00	
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	EMPLOYEE BENEFITS	0	0	0	0	4.00
5.00	ADMINISTRATIVE & GENERAL	9,842	146,200	74,445	230,487	5.00
6.00	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	OPERATION OF PLANT	0	55,533	28,277	83,810	7.00
8.00	LAUNDRY & LINEN SERVICE	0	7,581	3,860	11,441	8.00
9.00	HOUSEKEEPING	0	7,107	3,619	10,726	9.00
10.00	DIETARY	0	26,369	13,427	39,796	10.00
11.00	CAFETERIA	0	6,207	3,161	9,368	11.00
12.00	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	NURSING ADMINISTRATION	0	1,706	869	2,575	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00	PHARMACY	0	0	0	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	706	17,567	8,945	27,218	16.00
17.00	SOCIAL SERVICE	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	2,163	124,795	63,546	190,504	30.00
42.00	SUBPROVIDER	0	0	0	0	42.00
43.00	NURSERY	0	1,481	754	2,235	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	52,895	91,509	46,596	191,000	50.00
51.00	RECOVERY ROOM	0	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	27,826	14,169	41,995	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	73,716	37,536	111,252	54.00
55.00	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
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)	260,905	0	0	260,905	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	LABORATORY	14,006	20,647	10,514	45,167	60.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	901	15,032	7,654	23,587	65.00
65.01	SLEEP LAB	0	806	410	1,216	65.01
66.00	PHYSICAL THERAPY	0	31,841	16,214	48,055	66.00
67.00	OCCUPATIONAL THERAPY	0	3,755	1,912	5,667	67.00
68.00	SPEECH PATHOLOGY	0	3,755	1,912	5,667	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	19,936	10,152	30,088	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	8,671	4,415	13,086	73.00
74.00	RENAL DIALYSIS	0	0	0	0	74.00
75.00	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS						
91.00	EMERGENCY	3,053	50,333	25,629	79,015	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
116.00	HOSPICE	0	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	344,471	742,373	378,016	1,464,860	118.00
NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,516	772	2,288	190.00
191.00	RESEARCH	0	0	0	0	191.00
192.00	PHYSICIANS' PRIVATE OFFICES	342	183,930	93,658	277,930	192.00
193.00	NONPAID WORKERS	0	0	0	0	193.00
194.00	OTHER NRCC - PUBLIC RELATIONS	0	782	398	1,180	194.00
194.01	OTHER NRCC - FOUNDATION	0	782	398	1,180	194.01
194.02	OTHER NRCC - GRANTS	0	0	0	0	194.02
200.00	Cross Foot Adjustments	0	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	344,813	929,383	473,242	1,747,438	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151301

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

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Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
	5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS						
1.00 CAP REL COSTS-BLDG & FIXT						1.00
2.00 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 EMPLOYEE BENEFITS						4.00
5.00 ADMINISTRATIVE & GENERAL	230,487					5.00
6.00 MAINTENANCE & REPAIRS	0	0				6.00
7.00 OPERATION OF PLANT	17,410	0	101,220			7.00
8.00 LAUNDRY & LINEN SERVICE	807	0	1,055	13,303		8.00
9.00 HOUSEKEEPING	5,405	0	989	0	17,120	9.00
10.00 DIETARY	2,364	0	3,668	0	633	10.00
11.00 CAFETERIA	4,051	0	863	0	149	11.00
12.00 MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00 NURSING ADMINISTRATION	9,115	0	237	0	41	13.00
14.00 CENTRAL SERVICES & SUPPLY	1,851	0	0	0	0	14.00
15.00 PHARMACY	13,938	0	0	0	0	15.00
16.00 MEDICAL RECORDS & LIBRARY	4,226	0	2,444	0	422	16.00
17.00 SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	32,891	0	17,360	5,656	2,997	30.00
42.00 SUBPROVIDER	0	0	0	0	0	42.00
43.00 NURSERY	6,643	0	206	0	36	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	14,648	0	12,729	1,788	2,197	50.00
51.00 RECOVERY ROOM	0	0	0	0	0	51.00
52.00 DELIVERY ROOM & LABOR ROOM	546	0	3,871	0	668	52.00
53.00 ANESTHESIOLOGY	679	0	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	13,830	0	10,254	1,161	1,770	54.00
55.00 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00 RADIOISOTOPE	0	0	0	0	0	56.00
57.00 CT SCAN	2,513	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	4,043	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 LABORATORY	24,444	0	2,872	0	496	60.00
64.00 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 RESPIRATORY THERAPY	6,444	0	2,091	0	361	65.00
65.01 SLEEP LAB	676	0	112	0	19	65.01
66.00 PHYSICAL THERAPY	6,509	0	4,429	0	765	66.00
67.00 OCCUPATIONAL THERAPY	1,384	0	522	0	90	67.00
68.00 SPEECH PATHOLOGY	270	0	522	0	90	68.00
69.00 ELECTROCARDIOLOGY	2,469	0	0	0	0	69.00
70.00 ELECTROENCEPHALOGRAPHY	68	0	0	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	5,707	0	2,773	0	479	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	6,669	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	1,268	0	1,206	0	208	73.00
74.00 RENAL DIALYSIS	0	0	0	0	0	74.00
75.00 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS						
91.00 EMERGENCY	27,412	0	7,002	4,698	1,209	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
116.00 HOSPICE	0	0	0	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	218,280	0	75,205	13,303	12,630	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	30	0	211	0	36	190.00
191.00 RESEARCH	0	0	0	0	0	191.00
192.00 PHYSICIANS' PRIVATE OFFICES	4,394	0	25,586	0	4,416	192.00
193.00 NONPAID WORKERS	0	0	0	0	0	193.00
194.00 OTHER NRCC - PUBLIC RELATIONS	4,275	0	109	0	19	194.00
194.01 OTHER NRCC - FOUNDATION	2,332	0	109	0	19	194.01
194.02 OTHER NRCC - GRANTS	1,176	0	0	0	0	194.02
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)	230,487	0	101,220	13,303	17,120	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151301

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

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
		10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
6.00	MAINTENANCE & REPAIRS						6.00
7.00	OPERATION OF PLANT						7.00
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING						9.00
10.00	DIETARY	46,461					10.00
11.00	CAFETERIA	0	14,431				11.00
12.00	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	NURSING ADMINISTRATION	0	302	0	12,270		13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	0	0	1,851	14.00
15.00	PHARMACY	0	0	0	0	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	0	778	0	0	0	16.00
17.00	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	46,461	3,575	0	6,910	0	30.00
42.00	SUBPROVIDER	0	0	0	0	0	42.00
43.00	NURSERY	0	610	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	0	879	0	1,698	0	50.00
51.00	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	1,358	0	0	0	54.00
55.00	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
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
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	0	1,993	0	0	0	60.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	0	680	0	0	0	65.00
65.01	SLEEP LAB	0	0	0	0	0	65.01
66.00	PHYSICAL THERAPY	0	628	0	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	233	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	15	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	267	0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	283	0	0	821	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1,030	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	312	0	0	0	73.00
74.00	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS							
91.00	EMERGENCY	0	1,729	0	3,341	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
116.00	HOSPICE	0	0	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	46,461	13,642	0	11,949	1,851	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	RESEARCH	0	0	0	0	0	191.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	166	0	321	0	192.00
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	OTHER NRCC - PUBLIC RELATIONS	0	403	0	0	0	194.00
194.01	OTHER NRCC - FOUNDATION	0	115	0	0	0	194.01
194.02	OTHER NRCC - GRANTS	0	105	0	0	0	194.02
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)	46,461	14,431	0	12,270	1,851	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151301

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

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
	15.00	16.00	17.00	24.00	25.00	
GENERAL SERVICE COST CENTERS						
1.00 CAP REL COSTS-BLDG & FIXT						1.00
2.00 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 EMPLOYEE BENEFITS						4.00
5.00 ADMINISTRATIVE & GENERAL						5.00
6.00 MAINTENANCE & REPAIRS						6.00
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
12.00 MAINTENANCE OF PERSONNEL						12.00
13.00 NURSING ADMINISTRATION						13.00
14.00 CENTRAL SERVICES & SUPPLY						14.00
15.00 PHARMACY	13,938					15.00
16.00 MEDICAL RECORDS & LIBRARY	0	35,088				16.00
17.00 SOCIAL SERVICE	0	0	0			17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	0	2,545	0	308,899	0	30.00
42.00 SUBPROVIDER	0	0	0	0	0	42.00
43.00 NURSERY	0	284	0	10,014	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	3,771	0	228,710	0	50.00
51.00 RECOVERY ROOM	0	0	0	0	0	51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	94	0	47,174	0	52.00
53.00 ANESTHESIOLOGY	0	303	0	982	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	3,218	0	142,843	0	54.00
55.00 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00 RADIOISOTOPE	0	0	0	0	0	56.00
57.00 CT SCAN	0	4,130	0	6,643	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	1,320	0	266,268	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 LABORATORY	0	7,507	0	82,479	0	60.00
64.00 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 RESPIRATORY THERAPY	0	774	0	33,937	0	65.00
65.01 SLEEP LAB	0	190	0	2,213	0	65.01
66.00 PHYSICAL THERAPY	0	1,069	0	61,455	0	66.00
67.00 OCCUPATIONAL THERAPY	0	206	0	8,102	0	67.00
68.00 SPEECH PATHOLOGY	0	13	0	6,577	0	68.00
69.00 ELECTROCARDIOLOGY	0	544	0	3,280	0	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	63	0	131	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,376	0	41,527	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	320	0	8,019	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	13,938	2,938	0	32,956	0	73.00
74.00 RENAL DIALYSIS	0	0	0	0	0	74.00
75.00 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS						
91.00 EMERGENCY	0	4,423	0	128,829	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
116.00 HOSPICE	0	0	0	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	13,938	35,088	0	1,421,038	0	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	2,565	0	190.00
191.00 RESEARCH	0	0	0	0	0	191.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	312,813	0	192.00
193.00 NONPAID WORKERS	0	0	0	0	0	193.00
194.00 OTHER NRCC - PUBLIC RELATIONS	0	0	0	5,986	0	194.00
194.01 OTHER NRCC - FOUNDATION	0	0	0	3,755	0	194.01
194.02 OTHER NRCC - GRANTS	0	0	0	1,281	0	194.02
200.00 Cross Foot Adjustments				0	0	200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	13,938	35,088	0	1,747,438	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151301

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

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	CAP REL COSTS-BLDG & FIXT		1.00
2.00	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	EMPLOYEE BENEFITS		4.00
5.00	ADMINISTRATIVE & GENERAL		5.00
6.00	MAINTENANCE & REPAIRS		6.00
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
12.00	MAINTENANCE OF PERSONNEL		12.00
13.00	NURSING ADMINISTRATION		13.00
14.00	CENTRAL SERVICES & SUPPLY		14.00
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	308,899	30.00
42.00	SUBPROVIDER	0	42.00
43.00	NURSERY	10,014	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	OPERATING ROOM	228,710	50.00
51.00	RECOVERY ROOM	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	47,174	52.00
53.00	ANESTHESIOLOGY	982	53.00
54.00	RADIOLOGY-DIAGNOSTIC	142,843	54.00
55.00	RADIOLOGY-THERAPEUTIC	0	55.00
56.00	RADIOISOTOPE	0	56.00
57.00	CT SCAN	6,643	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	266,268	58.00
59.00	CARDIAC CATHETERIZATION	0	59.00
60.00	LABORATORY	82,479	60.00
64.00	INTRAVENOUS THERAPY	0	64.00
65.00	RESPIRATORY THERAPY	33,937	65.00
65.01	SLEEP LAB	2,213	65.01
66.00	PHYSICAL THERAPY	61,455	66.00
67.00	OCCUPATIONAL THERAPY	8,102	67.00
68.00	SPEECH PATHOLOGY	6,577	68.00
69.00	ELECTROCARDIOLOGY	3,280	69.00
70.00	ELECTROENCEPHALOGRAPHY	131	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	41,527	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	8,019	72.00
73.00	DRUGS CHARGED TO PATIENTS	32,956	73.00
74.00	RENAL DIALYSIS	0	74.00
75.00	ASC (NON-DISTINCT PART)	0	75.00
OUTPATIENT SERVICE COST CENTERS			
91.00	EMERGENCY	128,829	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)		92.00
OTHER REIMBURSABLE COST CENTERS			
101.00	HOME HEALTH AGENCY	0	101.00
SPECIAL PURPOSE COST CENTERS			
116.00	HOSPICE	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	1,421,038	118.00
NONREIMBURSABLE COST CENTERS			
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,565	190.00
191.00	RESEARCH	0	191.00
192.00	PHYSICIANS' PRIVATE OFFICES	312,813	192.00
193.00	NONPAID WORKERS	0	193.00
194.00	OTHER NRCC - PUBLIC RELATIONS	5,986	194.00
194.01	OTHER NRCC - FOUNDATION	3,755	194.01
194.02	OTHER NRCC - GRANTS	1,281	194.02
200.00	Cross Foot Adjustments	0	200.00
201.00	Negative Cost Centers	0	201.00
202.00	TOTAL (sum lines 118-201)	1,747,438	202.00

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCU. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)					
	1.00	2.00	4.00				
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	78,457					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		78,457				2.00
4.00	EMPLOYEE BENEFITS	0	0	10,066,512			4.00
5.00	ADMINISTRATIVE & GENERAL	12,342	12,342	2,191,645	-5,413,024	17,719,054	5.00
6.00	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	OPERATION OF PLANT	4,688	4,688	218,301	0	1,338,411	7.00
8.00	LAUNDRY & LINEN SERVICE	640	640	0	0	62,033	8.00
9.00	HOUSEKEEPING	600	600	238,985	0	415,546	9.00
10.00	DIETARY	2,226	2,226	75,102	0	181,765	10.00
11.00	CAFETERIA	524	524	213,792	0	311,391	11.00
12.00	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	NURSING ADMINISTRATION	144	144	502,094	0	700,726	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	84,771	0	142,296	14.00
15.00	PHARMACY	0	0	241,705	0	1,071,478	15.00
16.00	MEDICAL RECORDS & LIBRARY	1,483	1,483	189,049	0	324,887	16.00
17.00	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	10,535	10,535	2,060,072	0	2,528,637	30.00
42.00	SUBPROVIDER	0	0	0	0	0	42.00
43.00	NURSERY	125	125	351,430	0	510,651	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	7,725	7,725	469,042	0	1,126,091	50.00
51.00	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	2,349	2,349	0	0	41,995	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	52,184	53.00
54.00	RADIOLOGY-DIAGNOSTIC	6,223	6,223	669,577	0	1,063,185	54.00
55.00	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	CT SCAN	0	0	35,460	0	193,223	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	36,802	0	310,783	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	1,743	1,743	629,863	0	1,879,134	60.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	1,269	1,269	331,353	0	495,373	65.00
65.01	SLEEP LAB	68	68	0	0	51,995	65.01
66.00	PHYSICAL THERAPY	2,688	2,688	322,425	0	500,418	66.00
67.00	OCCUPATIONAL THERAPY	317	317	73,121	0	106,394	67.00
68.00	SPEECH PATHOLOGY	317	317	11,277	0	20,734	68.00
69.00	ELECTROCARDIOLOGY	0	0	130,224	0	189,831	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	5,260	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,683	1,683	0	0	438,767	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	512,656	72.00
73.00	DRUGS CHARGED TO PATIENTS	732	732	57,633	0	97,496	73.00
74.00	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS							
91.00	EMERGENCY	4,249	4,249	793,050	0	2,107,304	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
116.00	HOSPICE	0	0	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	62,670	62,670	9,926,773	-5,413,024	16,780,644	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	128	128	0	0	2,288	190.00
191.00	RESEARCH	0	0	0	0	0	191.00
192.00	PHYSICIANS' PRIVATE OFFICES	15,527	15,527	43,679	0	337,769	192.00
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	OTHER NRCC - PUBLIC RELATIONS	66	66	32,594	0	328,642	194.00
194.01	OTHER NRCC - FOUNDATION	66	66	63,466	0	179,308	194.01
194.02	OTHER NRCC - GRANTS	0	0	0	0	90,403	194.02
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)	929,383	473,242	3,382,823		5,413,024	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	11.845763	6.031865	0.336047		0.305492	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			0		230,487	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000000		0.013008	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151301

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

Worksheet B-1

Date/Time Prepared:
1/26/2012 10:02 am

Cost Center Description	MAINTENANCE & REPAIRS (ASSIGNED TIME)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
	6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	EMPLOYEE BENEFITS					4.00
5.00	ADMINISTRATIVE & GENERAL					5.00
6.00	MAINTENANCE & REPAIRS	0				6.00
7.00	OPERATION OF PLANT	0	61,427			7.00
8.00	LAUNDRY & LINEN SERVICE	0	640	109,989		8.00
9.00	HOUSEKEEPING	0	600	0	60,187	9.00
10.00	DIETARY	0	2,226	0	2,226	100
11.00	CAFETERIA	0	524	0	524	0
12.00	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00	NURSING ADMINISTRATION	0	144	0	144	0
14.00	CENTRAL SERVICES & SUPPLY	0	0	0	0	0
15.00	PHARMACY	0	0	0	0	0
16.00	MEDICAL RECORDS & LIBRARY	0	1,483	0	1,483	0
17.00	SOCIAL SERVICE	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	0	10,535	46,758	10,535	100
42.00	SUBPROVIDER	0	0	0	0	0
43.00	NURSERY	0	125	0	125	0
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	7,725	14,787	7,725	0
51.00	RECOVERY ROOM	0	0	0	0	0
52.00	DELIVERY ROOM & LABOR ROOM	0	2,349	0	2,349	0
53.00	ANESTHESIOLOGY	0	0	0	0	0
54.00	RADIOLOGY-DIAGNOSTIC	0	6,223	9,598	6,223	0
55.00	RADIOLOGY-THERAPEUTIC	0	0	0	0	0
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
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	LABORATORY	0	1,743	0	1,743	0
64.00	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	RESPIRATORY THERAPY	0	1,269	0	1,269	0
65.01	SLEEP LAB	0	68	0	68	0
66.00	PHYSICAL THERAPY	0	2,688	0	2,688	0
67.00	OCCUPATIONAL THERAPY	0	317	0	317	0
68.00	SPEECH PATHOLOGY	0	317	0	317	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	1,683	0	1,683	0
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	DRUGS CHARGED TO PATIENTS	0	732	0	732	0
74.00	RENAL DIALYSIS	0	0	0	0	0
75.00	ASC (NON-DISTINCT PART)	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS						
91.00	EMERGENCY	0	4,249	38,846	4,249	0
92.00	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	HOME HEALTH AGENCY	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
116.00	HOSPICE	0	0	0	0	0
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	45,640	109,989	44,400	100
NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	128	0	128	0
191.00	RESEARCH	0	0	0	0	0
192.00	PHYSICIANS' PRIVATE OFFICES	0	15,527	0	15,527	0
193.00	NONPAID WORKERS	0	0	0	0	0
194.00	OTHER NRCC - PUBLIC RELATIONS	0	66	0	66	0
194.01	OTHER NRCC - FOUNDATION	0	66	0	66	0
194.02	OTHER NRCC - GRANTS	0	0	0	0	0
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per wkst. B, Part I)	0	1,747,285	99,189	559,559	321,306
203.00	Unit cost multiplier (wkst. B, Part I)	0.000000	28.444902	0.901808	9.297008	3,213.060000
204.00	Cost to be allocated (per wkst. B, Part II)	0	101,220	13,303	17,120	46,461
205.00	Unit cost multiplier (wkst. B, Part II)	0.000000	1.647810	0.120948	0.284447	464.610000

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151301

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

Worksheet B-1

Date/Time Prepared:
1/26/2012 10:02 am

Cost Center Description	CAFETERIA (HOURS)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
	11.00	12.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS						
1.00 CAP REL COSTS-BLDG & FIXT						1.00
2.00 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 EMPLOYEE BENEFITS						4.00
5.00 ADMINISTRATIVE & GENERAL						5.00
6.00 MAINTENANCE & REPAIRS						6.00
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	259,426					11.00
12.00 MAINTENANCE OF PERSONNEL	0	0				12.00
13.00 NURSING ADMINISTRATION	5,437	0	114,136			13.00
14.00 CENTRAL SERVICES & SUPPLY	0	0	0	921,335		14.00
15.00 PHARMACY	0	0	0	0	100	15.00
16.00 MEDICAL RECORDS & LIBRARY	13,980	0	0	0	0	16.00
17.00 SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	64,279	0	64,279	0	0	30.00
42.00 SUBPROVIDER	0	0	0	0	0	42.00
43.00 NURSERY	10,965	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	15,794	0	15,794	0	0	50.00
51.00 RECOVERY ROOM	0	0	0	0	0	51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	24,418	0	0	0	0	54.00
55.00 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
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
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 LABORATORY	35,828	0	0	0	0	60.00
64.00 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 RESPIRATORY THERAPY	12,221	0	0	0	0	65.00
65.01 SLEEP LAB	0	0	0	0	0	65.01
66.00 PHYSICAL THERAPY	11,285	0	0	0	0	66.00
67.00 OCCUPATIONAL THERAPY	4,192	0	0	0	0	67.00
68.00 SPEECH PATHOLOGY	262	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	4,795	0	0	0	0	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	5,088	0	0	408,679	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	512,656	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	5,606	0	0	0	100	73.00
74.00 RENAL DIALYSIS	0	0	0	0	0	74.00
75.00 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS						
91.00 EMERGENCY	31,074	0	31,074	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
116.00 HOSPICE	0	0	0	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	245,224	0	111,147	921,335	100	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00 RESEARCH	0	0	0	0	0	191.00
192.00 PHYSICIANS' PRIVATE OFFICES	2,989	0	2,989	0	0	192.00
193.00 NONPAID WORKERS	0	0	0	0	0	193.00
194.00 OTHER NRCC - PUBLIC RELATIONS	7,253	0	0	0	0	194.00
194.01 OTHER NRCC - FOUNDATION	2,074	0	0	0	0	194.01
194.02 OTHER NRCC - GRANTS	1,886	0	0	0	0	194.02
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)	426,295	0	929,161	185,766	1,398,806	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	1.643224	0.000000	8.140823	0.201627	13,988.060000	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	14,431	0	12,270	1,851	13,938	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)	0.055627	0.000000	0.107503	0.002009	139.380000	205.00

Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	
	16.00	17.00	
GENERAL SERVICE COST CENTERS			
1.00 CAP REL COSTS-BLDG & FIXT			1.00
2.00 CAP REL COSTS-MVBLE EQUIP			2.00
4.00 EMPLOYEE BENEFITS			4.00
5.00 ADMINISTRATIVE & GENERAL			5.00
6.00 MAINTENANCE & REPAIRS			6.00
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
12.00 MAINTENANCE OF PERSONNEL			12.00
13.00 NURSING ADMINISTRATION			13.00
14.00 CENTRAL SERVICES & SUPPLY			14.00
15.00 PHARMACY			15.00
16.00 MEDICAL RECORDS & LIBRARY	70,463,683		16.00
17.00 SOCIAL SERVICE	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00 ADULTS & PEDIATRICS	5,110,774	0	30.00
42.00 SUBPROVIDER	0	0	42.00
43.00 NURSERY	570,894	0	43.00
ANCILLARY SERVICE COST CENTERS			
50.00 OPERATING ROOM	7,573,046	0	50.00
51.00 RECOVERY ROOM	0	0	51.00
52.00 DELIVERY ROOM & LABOR ROOM	189,216	0	52.00
53.00 ANESTHESIOLOGY	608,358	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	6,461,002	0	54.00
55.00 RADIOLOGY-THERAPEUTIC	0	0	55.00
56.00 RADIOISOTOPE	0	0	56.00
57.00 CT SCAN	8,293,076	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	2,651,175	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	59.00
60.00 LABORATORY	15,078,971	0	60.00
64.00 INTRAVENOUS THERAPY	0	0	64.00
65.00 RESPIRATORY THERAPY	1,555,192	0	65.00
65.01 SLEEP LAB	380,825	0	65.01
66.00 PHYSICAL THERAPY	2,145,855	0	66.00
67.00 OCCUPATIONAL THERAPY	413,373	0	67.00
68.00 SPEECH PATHOLOGY	25,655	0	68.00
69.00 ELECTROCARDIOLOGY	1,093,278	0	69.00
70.00 ELECTROENCEPHALOGRAPHY	127,153	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	2,763,478	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	642,112	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	5,898,754	0	73.00
74.00 RENAL DIALYSIS	0	0	74.00
75.00 ASC (NON-DISTINCT PART)	0	0	75.00
OUTPATIENT SERVICE COST CENTERS			
91.00 EMERGENCY	8,881,496	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)			92.00
OTHER REIMBURSABLE COST CENTERS			
101.00 HOME HEALTH AGENCY	0	0	101.00
SPECIAL PURPOSE COST CENTERS			
116.00 HOSPICE	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	70,463,683	0	118.00
NONREIMBURSABLE COST CENTERS			
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
191.00 RESEARCH	0	0	191.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	192.00
193.00 NONPAID WORKERS	0	0	193.00
194.00 OTHER NRCC - PUBLIC RELATIONS	0	0	194.00
194.01 OTHER NRCC - FOUNDATION	0	0	194.01
194.02 OTHER NRCC - GRANTS	0	0	194.02
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)	503,080	0	202.00
203.00 Unit cost multiplier (wkst. B, Part I)	0.007140	0.000000	203.00
204.00 Cost to be allocated (per wkst. B, Part II)	35,088	0	204.00
205.00 Unit cost multiplier (wkst. B, Part II)	0.000498	0.000000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151301

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

Worksheet C
Part I
Date/Time Prepared:
1/26/2012 10:02 am

		Title XVIII			Hospital		Cost
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			Total Costs	
			Total Costs	RCE Disallowance	Total Costs		
	1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	4,727,592		4,727,592	0	0	30.00
42.00	SUBPROVIDER	0		0	0	0	42.00
43.00	NURSERY	693,463		693,463	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	1,983,595		1,983,595	0	0	50.00
51.00	RECOVERY ROOM	0		0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	144,831		144,831	0	0	52.00
53.00	ANESTHESIOLOGY	72,470		72,470	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	1,717,760		1,717,760	0	0	54.00
55.00	RADIOLOGY-THERAPEUTIC	0		0	0	0	55.00
56.00	RADIOISOTOPE	0		0	0	0	56.00
57.00	CT SCAN	311,464		311,464	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	424,654		424,654	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	LABORATORY	2,685,484		2,685,484	0	0	60.00
64.00	INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	RESPIRATORY THERAPY	725,786	0	725,786	0	0	65.00
65.01	SLEEP LAB	73,164	0	73,164	0	0	65.01
66.00	PHYSICAL THERAPY	788,607	0	788,607	0	0	66.00
67.00	OCCUPATIONAL THERAPY	160,700	0	160,700	0	0	67.00
68.00	SPEECH PATHOLOGY	39,646	0	39,646	0	0	68.00
69.00	ELECTROCARDIOLOGY	263,508		263,508	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	7,775		7,775	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	746,820		746,820	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	777,218		777,218	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	1,605,042		1,605,042	0	0	73.00
74.00	RENAL DIALYSIS	0		0	0	0	74.00
75.00	ASC (NON-DISTINCT PART)	0		0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS							
91.00	EMERGENCY	3,313,910		3,313,910	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	778,892		778,892	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	HOME HEALTH AGENCY	0		0		0	101.00
SPECIAL PURPOSE COST CENTERS							
116.00	HOSPICE	0		0		0	116.00
200.00	Subtotal (see instructions)	22,042,381	0	22,042,381	0	0	200.00
201.00	Less Observation Beds	778,892		778,892		0	201.00
202.00	Total (see instructions)	21,263,489	0	21,263,489	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151301

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

Worksheet C
Part I
Date/Time Prepared:
1/26/2012 10:02 am

Cost Center Description	Charges			Hospital	Cost	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	4,115,366		4,115,366			30.00
42.00 SUBPROVIDER	0		0			42.00
43.00 NURSERY	570,894		570,894			43.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	1,578,656	5,994,390	7,573,046	0.261928	0.000000	50.00
51.00 RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00 DELIVERY ROOM & LABOR ROOM	189,216	0	189,216	0.765427	0.000000	52.00
53.00 ANESTHESIOLOGY	96,177	512,181	608,358	0.119124	0.000000	53.00
54.00 RADIOLOGY-DIAGNOSTIC	386,429	6,074,573	6,461,002	0.265866	0.000000	54.00
55.00 RADIOLOGY-THERAPEUTIC	0	0	0	0.000000	0.000000	55.00
56.00 RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
57.00 CT SCAN	842,211	7,450,865	8,293,076	0.037557	0.000000	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	121,735	2,529,440	2,651,175	0.160176	0.000000	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00 LABORATORY	1,864,082	13,214,889	15,078,971	0.178095	0.000000	60.00
64.00 INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
65.00 RESPIRATORY THERAPY	1,013,390	541,802	1,555,192	0.466686	0.000000	65.00
65.01 SLEEP LAB	0	380,825	380,825	0.192120	0.000000	65.01
66.00 PHYSICAL THERAPY	258,690	1,887,165	2,145,855	0.367502	0.000000	66.00
67.00 OCCUPATIONAL THERAPY	101,968	311,405	413,373	0.388753	0.000000	67.00
68.00 SPEECH PATHOLOGY	10,029	15,626	25,655	1.545352	0.000000	68.00
69.00 ELECTROCARDIOLOGY	258,628	834,650	1,093,278	0.241026	0.000000	69.00
70.00 ELECTROENCEPHALOGRAPHY	5,104	122,049	127,153	0.061147	0.000000	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	1,138,623	1,624,855	2,763,478	0.270246	0.000000	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	324,367	317,745	642,112	1.210409	0.000000	72.00
73.00 DRUGS CHARGED TO PATIENTS	2,742,050	3,156,704	5,898,754	0.272098	0.000000	73.00
74.00 RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
75.00 ASC (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	75.00
OUTPATIENT SERVICE COST CENTERS						
91.00 EMERGENCY	374,582	8,506,914	8,881,496	0.373125	0.000000	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	995,408	995,408	0.782485	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 HOME HEALTH AGENCY	0	0	0			101.00
SPECIAL PURPOSE COST CENTERS						
116.00 HOSPICE	0	0	0			116.00
200.00 Subtotal (see instructions)	15,992,197	54,471,486	70,463,683			200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	15,992,197	54,471,486	70,463,683			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 151301	Period: From 07/01/2010 To 06/30/2011	Worksheet C Part I Date/Time Prepared: 1/26/2012 10:02 am
	Title XVIII	Hospital	Cost

Cost Center Description	PPS Inpatient Ratio		Cost
	11.00		
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00 ADULTS & PEDIATRICS			30.00
42.00 SUBPROVIDER			42.00
43.00 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS			
50.00 OPERATING ROOM	0.000000		50.00
51.00 RECOVERY ROOM	0.000000		51.00
52.00 DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00 ANESTHESIOLOGY	0.000000		53.00
54.00 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
55.00 RADIOLOGY-THERAPEUTIC	0.000000		55.00
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
59.00 CARDIAC CATHETERIZATION	0.000000		59.00
60.00 LABORATORY	0.000000		60.00
64.00 INTRAVENOUS THERAPY	0.000000		64.00
65.00 RESPIRATORY THERAPY	0.000000		65.00
65.01 SLEEP LAB	0.000000		65.01
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
72.00 IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00 DRUGS CHARGED TO PATIENTS	0.000000		73.00
74.00 RENAL DIALYSIS	0.000000		74.00
75.00 ASC (NON-DISTINCT PART)	0.000000		75.00
OUTPATIENT SERVICE COST CENTERS			
91.00 EMERGENCY	0.000000		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS			
101.00 HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS			
116.00 HOSPICE			116.00
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: 151301

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

Worksheet C
Part I
Date/Time Prepared:
1/26/2012 10:02 am

Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Title XIX		Hospital		Total Costs
			Total Costs	RCE Disallowance	Total Costs	Cost	
			1.00	2.00	3.00	4.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	4,727,592		4,727,592	0	0	30.00
42.00	SUBPROVIDER	0		0	0	0	42.00
43.00	NURSERY	693,463		693,463	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	1,983,595		1,983,595	0	0	50.00
51.00	RECOVERY ROOM	0		0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	144,831		144,831	0	0	52.00
53.00	ANESTHESIOLOGY	72,470		72,470	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	1,717,760		1,717,760	0	0	54.00
55.00	RADIOLOGY-THERAPEUTIC	0		0	0	0	55.00
56.00	RADIOISOTOPE	0		0	0	0	56.00
57.00	CT SCAN	311,464		311,464	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	424,654		424,654	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	LABORATORY	2,685,484		2,685,484	0	0	60.00
64.00	INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	RESPIRATORY THERAPY	725,786	0	725,786	0	0	65.00
65.01	SLEEP LAB	73,164	0	73,164	0	0	65.01
66.00	PHYSICAL THERAPY	788,607	0	788,607	0	0	66.00
67.00	OCCUPATIONAL THERAPY	160,700	0	160,700	0	0	67.00
68.00	SPEECH PATHOLOGY	39,646	0	39,646	0	0	68.00
69.00	ELECTROCARDIOLOGY	263,508		263,508	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	7,775		7,775	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	746,820		746,820	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	777,218		777,218	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	1,605,042		1,605,042	0	0	73.00
74.00	RENAL DIALYSIS	0		0	0	0	74.00
75.00	ASC (NON-DISTINCT PART)	0		0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS							
91.00	EMERGENCY	3,313,910		3,313,910	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	778,892		778,892	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	HOME HEALTH AGENCY	0		0		0	101.00
SPECIAL PURPOSE COST CENTERS							
116.00	HOSPICE	0		0		0	116.00
200.00	Subtotal (see instructions)	22,042,381	0	22,042,381	0	0	200.00
201.00	Less Observation Beds	778,892		778,892			201.00
202.00	Total (see instructions)	21,263,489	0	21,263,489	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151301

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

Worksheet C
Part I
Date/Time Prepared:
1/26/2012 10:02 am

		Title XIX			Hospital	Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				
			9.00	10.00			
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	4,115,366		4,115,366			30.00
42.00	SUBPROVIDER	0		0			42.00
43.00	NURSERY	570,894		570,894			43.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	1,578,656	5,994,390	7,573,046	0.261928	0.000000	50.00
51.00	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00	DELIVERY ROOM & LABOR ROOM	189,216	0	189,216	0.765427	0.000000	52.00
53.00	ANESTHESIOLOGY	96,177	512,181	608,358	0.119124	0.000000	53.00
54.00	RADIOLOGY-DIAGNOSTIC	386,429	6,074,573	6,461,002	0.265866	0.000000	54.00
55.00	RADIOLOGY-THERAPEUTIC	0	0	0	0.000000	0.000000	55.00
56.00	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
57.00	CT SCAN	842,211	7,450,865	8,293,076	0.037557	0.000000	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	121,735	2,529,440	2,651,175	0.160176	0.000000	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	LABORATORY	1,864,082	13,214,889	15,078,971	0.178095	0.000000	60.00
64.00	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
65.00	RESPIRATORY THERAPY	1,013,390	541,802	1,555,192	0.466686	0.000000	65.00
65.01	SLEEP LAB	0	380,825	380,825	0.192120	0.000000	65.01
66.00	PHYSICAL THERAPY	258,690	1,887,165	2,145,855	0.367502	0.000000	66.00
67.00	OCCUPATIONAL THERAPY	101,968	311,405	413,373	0.388753	0.000000	67.00
68.00	SPEECH PATHOLOGY	10,029	15,626	25,655	1.545352	0.000000	68.00
69.00	ELECTROCARDIOLOGY	258,628	834,650	1,093,278	0.241026	0.000000	69.00
70.00	ELECTROENCEPHALOGRAPHY	5,104	122,049	127,153	0.061147	0.000000	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,138,623	1,624,855	2,763,478	0.270246	0.000000	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	324,367	317,745	642,112	1.210409	0.000000	72.00
73.00	DRUGS CHARGED TO PATIENTS	2,742,050	3,156,704	5,898,754	0.272098	0.000000	73.00
74.00	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
75.00	ASC (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	75.00
OUTPATIENT SERVICE COST CENTERS							
91.00	EMERGENCY	374,582	8,506,914	8,881,496	0.373125	0.000000	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	995,408	995,408	0.782485	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	HOME HEALTH AGENCY	0	0	0			101.00
SPECIAL PURPOSE COST CENTERS							
116.00	HOSPICE	0	0	0			116.00
200.00	Subtotal (see instructions)	15,992,197	54,471,486	70,463,683			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	15,992,197	54,471,486	70,463,683			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 151301	Period: From 07/01/2010 To 06/30/2011	Worksheet C Part I Date/Time Prepared: 1/26/2012 10:02 am
	Title XIX	Hospital	Cost

Cost Center Description	PPS Inpatient Ratio		Cost
	11.00		
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00 ADULTS & PEDIATRICS			30.00
42.00 SUBPROVIDER			42.00
43.00 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS			
50.00 OPERATING ROOM	0.000000		50.00
51.00 RECOVERY ROOM	0.000000		51.00
52.00 DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00 ANESTHESIOLOGY	0.000000		53.00
54.00 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
55.00 RADIOLOGY-THERAPEUTIC	0.000000		55.00
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
59.00 CARDIAC CATHETERIZATION	0.000000		59.00
60.00 LABORATORY	0.000000		60.00
64.00 INTRAVENOUS THERAPY	0.000000		64.00
65.00 RESPIRATORY THERAPY	0.000000		65.00
65.01 SLEEP LAB	0.000000		65.01
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
72.00 IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00 DRUGS CHARGED TO PATIENTS	0.000000		73.00
74.00 RENAL DIALYSIS	0.000000		74.00
75.00 ASC (NON-DISTINCT PART)	0.000000		75.00
OUTPATIENT SERVICE COST CENTERS			
91.00 EMERGENCY	0.000000		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS			
101.00 HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS			
116.00 HOSPICE			116.00
200.00 Subtotal (see instructions)			200.00
201.00 Less Observation Beds			201.00
202.00 Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 151301	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part II Date/Time Prepared: 1/26/2012 10:02 am
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Cost Center Description		Title XVIII			Hospital		
		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	228,710	7,573,046	0.030201	435,652	13,157	50.00
51.00	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	47,174	189,216	0.249313	0	0	52.00
53.00	ANESTHESIOLOGY	982	608,358	0.001614	26,884	43	53.00
54.00	RADIOLOGY-DIAGNOSTIC	142,843	6,461,002	0.022108	146,104	3,230	54.00
55.00	RADIOLOGY-THERAPEUTIC	0	0	0.000000	0	0	55.00
56.00	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	CT SCAN	6,643	8,293,076	0.000801	326,947	262	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	266,268	2,651,175	0.100434	73,204	7,352	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	LABORATORY	82,479	15,078,971	0.005470	928,056	5,076	60.00
64.00	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	RESPIRATORY THERAPY	33,937	1,555,192	0.021822	635,181	13,861	65.00
65.01	SLEEP LAB	2,213	380,825	0.005811	0	0	65.01
66.00	PHYSICAL THERAPY	61,455	2,145,855	0.028639	105,094	3,010	66.00
67.00	OCCUPATIONAL THERAPY	8,102	413,373	0.019600	48,623	953	67.00
68.00	SPEECH PATHOLOGY	6,577	25,655	0.256363	6,200	1,589	68.00
69.00	ELECTROCARDIOLOGY	3,280	1,093,278	0.003000	248,005	744	69.00
70.00	ELECTROENCEPHALOGRAPHY	131	127,153	0.001030	3,846	4	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	41,527	2,763,478	0.015027	641,984	9,647	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	8,019	642,112	0.012488	181,607	2,268	72.00
73.00	DRUGS CHARGED TO PATIENTS	32,956	5,898,754	0.005587	1,425,532	7,964	73.00
74.00	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
75.00	ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
OUTPATIENT SERVICE COST CENTERS							
91.00	EMERGENCY	128,829	8,881,496	0.014505	8,080	117	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	995,408	0.000000	0	0	92.00
200.00	Total (lines 50-199)	1,102,125	65,777,423		5,240,999	69,277	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151301

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

Worksheet D
Part IV
Date/Time Prepared:
1/26/2012 10:02 am

Cost Center Description	Title XVIII				Hospital	Total Cost (sum of col 1 through col. 4)	
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Cost		
	1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS							
50.00 OPERATING ROOM	0	0	0	0	0	0	50.00
51.00 RECOVERY ROOM	0	0	0	0	0	0	51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.00
53.00 ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
55.00 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	0	55.00
56.00 RADIOISOTOPE	0	0	0	0	0	0	56.00
57.00 CT SCAN	0	0	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	0	59.00
60.00 LABORATORY	0	0	0	0	0	0	60.00
64.00 INTRAVENOUS THERAPY	0	0	0	0	0	0	64.00
65.00 RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
65.01 SLEEP LAB	0	0	0	0	0	0	65.01
66.00 PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
74.00 RENAL DIALYSIS	0	0	0	0	0	0	74.00
75.00 ASC (NON-DISTINCT PART)	0	0	0	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS							
91.00 EMERGENCY	0	0	0	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00
200.00 Total (lines 50-199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151301	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part IV Date/Time Prepared: 1/26/2012 10:02 am
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Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital Cost		
				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
	6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	7,573,046	0.000000	0.000000	435,652	50.00
51.00 RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	189,216	0.000000	0.000000	0	52.00
53.00 ANESTHESIOLOGY	0	608,358	0.000000	0.000000	26,884	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	6,461,002	0.000000	0.000000	146,104	54.00
55.00 RADIOLOGY-THERAPEUTIC	0	0	0.000000	0.000000	0	55.00
56.00 RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
57.00 CT SCAN	0	8,293,076	0.000000	0.000000	326,947	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	2,651,175	0.000000	0.000000	73,204	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00 LABORATORY	0	15,078,971	0.000000	0.000000	928,056	60.00
64.00 INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0	64.00
65.00 RESPIRATORY THERAPY	0	1,555,192	0.000000	0.000000	635,181	65.00
65.01 SLEEP LAB	0	380,825	0.000000	0.000000	0	65.01
66.00 PHYSICAL THERAPY	0	2,145,855	0.000000	0.000000	105,094	66.00
67.00 OCCUPATIONAL THERAPY	0	413,373	0.000000	0.000000	48,623	67.00
68.00 SPEECH PATHOLOGY	0	25,655	0.000000	0.000000	6,200	68.00
69.00 ELECTROCARDIOLOGY	0	1,093,278	0.000000	0.000000	248,005	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	127,153	0.000000	0.000000	3,846	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,763,478	0.000000	0.000000	641,984	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	642,112	0.000000	0.000000	181,607	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	5,898,754	0.000000	0.000000	1,425,532	73.00
74.00 RENAL DIALYSIS	0	0	0.000000	0.000000	0	74.00
75.00 ASC (NON-DISTINCT PART)	0	0	0.000000	0.000000	0	75.00
OUTPATIENT SERVICE COST CENTERS						
91.00 EMERGENCY	0	8,881,496	0.000000	0.000000	8,080	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	995,408	0.000000	0.000000	0	92.00
200.00 Total (lines 50-199)	0	65,777,423			5,240,999	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151301

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

Worksheet D
Part IV
Date/Time Prepared:
1/26/2012 10:02 am

Cost Center Description		Title XVIII			Hospital		
		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	0	0	0	0	0	50.00
51.00	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
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
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	0	0	0	0	0	60.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	0	0	0	0	0	65.00
65.01	SLEEP LAB	0	0	0	0	0	65.01
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
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS							
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: 151301	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part IV Date/Time Prepared: 1/26/2012 10:02 am
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Cost Center Description	Title XVIII		Hospital	Cost
	PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost		
	23.00	24.00		
ANCILLARY SERVICE COST CENTERS				
50.00 OPERATING ROOM	0	0		50.00
51.00 RECOVERY ROOM	0	0		51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 ANESTHESIOLOGY	0	0		53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00 RADIOLOGY-THERAPEUTIC	0	0		55.00
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
59.00 CARDIAC CATHETERIZATION	0	0		59.00
60.00 LABORATORY	0	0		60.00
64.00 INTRAVENOUS THERAPY	0	0		64.00
65.00 RESPIRATORY THERAPY	0	0		65.00
65.01 SLEEP LAB	0	0		65.01
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
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00 RENAL DIALYSIS	0	0		74.00
75.00 ASC (NON-DISTINCT PART)	0	0		75.00
OUTPATIENT SERVICE COST CENTERS				
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: 151301	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part V Date/Time Prepared: 1/26/2012 10:02 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
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0.261928	0	1,886,611	0	50.00
51.00	RECOVERY ROOM	0.000000	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0.765427	0	0	0	52.00
53.00	ANESTHESIOLOGY	0.119124	0	176,750	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.265866	0	1,450,085	0	54.00
55.00	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	55.00
56.00	RADIOISOTOPE	0.000000	0	0	0	56.00
57.00	CT SCAN	0.037557	0	2,460,657	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.160176	0	698,898	0	58.00
59.00	CARDIAC CATHETERIZATION	0.000000	0	0	0	59.00
60.00	LABORATORY	0.178095	0	4,279,225	0	60.00
64.00	INTRAVENOUS THERAPY	0.000000	0	0	0	64.00
65.00	RESPIRATORY THERAPY	0.466686	0	185,305	0	65.00
65.01	SLEEP LAB	0.192120	0	0	0	65.01
66.00	PHYSICAL THERAPY	0.367502	0	508,668	0	66.00
67.00	OCCUPATIONAL THERAPY	0.388753	0	64,535	0	67.00
68.00	SPEECH PATHOLOGY	1.545352	0	8,465	0	68.00
69.00	ELECTROCARDIOLOGY	0.241026	0	600,772	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0.061147	0	122,049	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.270246	0	610,096	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	1.210409	0	108,809	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.272098	0	1,116,124	772	73.00
74.00	RENAL DIALYSIS	0.000000	0	0	0	74.00
75.00	ASC (NON-DISTINCT PART)	0.000000	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS						
91.00	EMERGENCY	0.373125	0	2,258,112	886	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.782485	0	313,243	0	92.00
200.00	Subtotal (see instructions)		0	16,848,404	1,658	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	16,848,404	1,658	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151301	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part V Date/Time Prepared: 1/26/2012 10:02 am
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		Title XVIII			Hospital	Cost
Cost Center Description		Costs				
		PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)		
		5.00	6.00	7.00		
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	494,156	0		50.00
51.00	RECOVERY ROOM	0	0	0		51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	ANESTHESIOLOGY	0	21,055	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	385,528	0		54.00
55.00	RADIOLOGY-THERAPEUTIC	0	0	0		55.00
56.00	RADIOISOTOPE	0	0	0		56.00
57.00	CT SCAN	0	92,415	0		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	111,947	0		58.00
59.00	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	LABORATORY	0	762,109	0		60.00
64.00	INTRAVENOUS THERAPY	0	0	0		64.00
65.00	RESPIRATORY THERAPY	0	86,479	0		65.00
65.01	SLEEP LAB	0	0	0		65.01
66.00	PHYSICAL THERAPY	0	186,937	0		66.00
67.00	OCCUPATIONAL THERAPY	0	25,088	0		67.00
68.00	SPEECH PATHOLOGY	0	13,081	0		68.00
69.00	ELECTROCARDIOLOGY	0	144,802	0		69.00
70.00	ELECTROENCEPHALOGRAPHY	0	7,463	0		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	164,876	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	131,703	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	303,695	210		73.00
74.00	RENAL DIALYSIS	0	0	0		74.00
75.00	ASC (NON-DISTINCT PART)	0	0	0		75.00
OUTPATIENT SERVICE COST CENTERS						
91.00	EMERGENCY	0	842,558	331		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	245,108	0		92.00
200.00	Subtotal (see instructions)	0	4,019,000	541		200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00	Net Charges (line 200 +/- line 201)	0	4,019,000	541		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151301 Component CCN:15Z301	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part V Date/Time Prepared: 1/26/2012 10:02 am
Title XVIII		Swing Beds - SNF	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	0.261928	0	0	0	50.00
51.00	RECOVERY ROOM	0.000000	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0.765427	0	0	0	52.00
53.00	ANESTHESIOLOGY	0.119124	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.265866	0	0	0	54.00
55.00	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	55.00
56.00	RADIOISOTOPE	0.000000	0	0	0	56.00
57.00	CT SCAN	0.037557	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.160176	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0.000000	0	0	0	59.00
60.00	LABORATORY	0.178095	0	0	0	60.00
64.00	INTRAVENOUS THERAPY	0.000000	0	0	0	64.00
65.00	RESPIRATORY THERAPY	0.466686	0	0	0	65.00
65.01	SLEEP LAB	0.192120	0	0	0	65.01
66.00	PHYSICAL THERAPY	0.367502	0	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0.388753	0	0	0	67.00
68.00	SPEECH PATHOLOGY	1.545352	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0.241026	0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0.061147	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.270246	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	1.210409	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.272098	0	0	0	73.00
74.00	RENAL DIALYSIS	0.000000	0	0	0	74.00
75.00	ASC (NON-DISTINCT PART)	0.000000	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS						
91.00	EMERGENCY	0.373125	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.782485	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: 151301 Component CCN: 15Z301	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part V Date/Time Prepared: 1/26/2012 10:02 am
Title XVIII		Swing Beds - SNF	Cost

Cost Center Description	Costs				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
51.00	RECOVERY ROOM	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	ANESTHESIOLOGY	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
55.00	RADIOLOGY-THERAPEUTIC	0	0	0	55.00
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
59.00	CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	LABORATORY	0	0	0	60.00
64.00	INTRAVENOUS THERAPY	0	0	0	64.00
65.00	RESPIRATORY THERAPY	0	0	0	65.00
65.01	SLEEP LAB	0	0	0	65.01
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
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	73.00
74.00	RENAL DIALYSIS	0	0	0	74.00
75.00	ASC (NON-DISTINCT PART)	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS					
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: 151301		Period: From 07/01/2010 To 06/30/2011		Worksheet D Part I Date/Time Prepared: 1/26/2012 10:02 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)	Hospital Total Patient Days	Cost 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	308,899	29,456	279,443	4,206	66.44	30.00
42.00	SUBPROVIDER	0	0	0	0	0.00	42.00
43.00	NURSERY	10,014		10,014	432	23.18	43.00
200.00	Total (lines 30-199)	318,913		289,457	4,638		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS	Provider CCN: 151301	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part I Date/Time Prepared: 1/26/2012 10:02 am
	Title XIX	Hospital	Cost

Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
	6.00	7.00	
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00 ADULTS & PEDIATRICS	571	37,937	30.00
42.00 SUBPROVIDER	0	0	42.00
43.00 NURSERY	283	6,560	43.00
200.00 Total (Lines 30-199)	854	44,497	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 151301	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part II Date/Time Prepared: 1/26/2012 10:02 am
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Cost Center Description	Title XIX					Capital Costs (column 3 x column 4)	
	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Hospital Inpatient Program Charges	Cost		
	1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	228,710	7,573,046	0.030201	352,291	10,640	50.00
51.00	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	47,174	189,216	0.249313	0	0	52.00
53.00	ANESTHESIOLOGY	982	608,358	0.001614	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	142,843	6,461,002	0.022108	40,980	906	54.00
55.00	RADIOLOGY-THERAPEUTIC	0	0	0.000000	0	0	55.00
56.00	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	CT SCAN	6,643	8,293,076	0.000801	54,869	44	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	266,268	2,651,175	0.100434	2,646	266	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	LABORATORY	82,479	15,078,971	0.005470	349,920	1,914	60.00
64.00	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	RESPIRATORY THERAPY	33,937	1,555,192	0.021822	114,279	2,494	65.00
65.01	SLEEP LAB	2,213	380,825	0.005811	0	0	65.01
66.00	PHYSICAL THERAPY	61,455	2,145,855	0.028639	3,994	114	66.00
67.00	OCCUPATIONAL THERAPY	8,102	413,373	0.019600	1,165	23	67.00
68.00	SPEECH PATHOLOGY	6,577	25,655	0.256363	753	193	68.00
69.00	ELECTROCARDIOLOGY	3,280	1,093,278	0.003000	6,174	19	69.00
70.00	ELECTROENCEPHALOGRAPHY	131	127,153	0.001030	707	1	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	41,527	2,763,478	0.015027	53,842	809	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	8,019	642,112	0.012488	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	32,956	5,898,754	0.005587	366,651	2,048	73.00
74.00	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
75.00	ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
OUTPATIENT SERVICE COST CENTERS							
91.00	EMERGENCY	128,829	8,881,496	0.014505	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	995,408	0.000000	0	0	92.00
200.00	Total (lines 50-199)	1,102,125	65,777,423		1,348,271	19,471	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 151301		Period: From 07/01/2010 To 06/30/2011		Worksheet D Part III Date/Time Prepared: 1/26/2012 10:02 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	0	30.00
42.00	SUBPROVIDER	0	0	0	0	0	0	42.00
43.00	NURSERY	0	0	0	0	0	0	43.00
200.00	Total (lines 30-199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 151301		Period: From 07/01/2010 To 06/30/2011		Worksheet D Part III Date/Time Prepared: 1/26/2012 10:02 am	
Cost Center Description		Title XIX		Hospital		Cost	
		Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. Nursing School	
		6.00	7.00	8.00	9.00	11.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	4,206	0.00	571	0	0	30.00
42.00	SUBPROVIDER	0	0.00	0	0	0	42.00
43.00	NURSERY	432	0.00	283	0	0	43.00
200.00	Total (lines 30-199)	4,638		854	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 151301		Period: From 07/01/2010 To 06/30/2011		Worksheet D Part III Date/Time Prepared: 1/26/2012 10:02 am	
Cost Center Description		PSA Adj. Allied Health Cost	PSA Adj. All Other Medical Education Cost	Title XIX		Hospital Cost	
		12.00	13.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	0	0			30.00	
42.00	SUBPROVIDER	0	0			42.00	
43.00	NURSERY	0	0			43.00	
200.00	Total (lines 30-199)	0	0			200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151301

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

Worksheet D
Part IV
Date/Time Prepared:
1/26/2012 10:02 am

Cost Center Description	Title XIX				Hospital	Total Cost (sum of col 1 through col. 4)
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Cost	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	0	0	0	0	50.00
51.00 RECOVERY ROOM	0	0	0	0	0	51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
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
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 LABORATORY	0	0	0	0	0	60.00
64.00 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 RESPIRATORY THERAPY	0	0	0	0	0	65.00
65.01 SLEEP LAB	0	0	0	0	0	65.01
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
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00 RENAL DIALYSIS	0	0	0	0	0	74.00
75.00 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS						
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: 151301

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

Worksheet D
Part IV
Date/Time Prepared:
1/26/2012 10:02 am

Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Title XIX		Hospital		Cost
		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	7,573,046	0.000000	0.000000	352,291 50.00
51.00	RECOVERY ROOM	0	0	0.000000	0.000000	0 51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	189,216	0.000000	0.000000	0 52.00
53.00	ANESTHESIOLOGY	0	608,358	0.000000	0.000000	0 53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	6,461,002	0.000000	0.000000	40,980 54.00
55.00	RADIOLOGY-THERAPEUTIC	0	0	0.000000	0.000000	0 55.00
56.00	RADIOISOTOPE	0	0	0.000000	0.000000	0 56.00
57.00	CT SCAN	0	8,293,076	0.000000	0.000000	54,869 57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	2,651,175	0.000000	0.000000	2,646 58.00
59.00	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0 59.00
60.00	LABORATORY	0	15,078,971	0.000000	0.000000	349,920 60.00
64.00	INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0 64.00
65.00	RESPIRATORY THERAPY	0	1,555,192	0.000000	0.000000	114,279 65.00
65.01	SLEEP LAB	0	380,825	0.000000	0.000000	0 65.01
66.00	PHYSICAL THERAPY	0	2,145,855	0.000000	0.000000	3,994 66.00
67.00	OCCUPATIONAL THERAPY	0	413,373	0.000000	0.000000	1,165 67.00
68.00	SPEECH PATHOLOGY	0	25,655	0.000000	0.000000	753 68.00
69.00	ELECTROCARDIOLOGY	0	1,093,278	0.000000	0.000000	6,174 69.00
70.00	ELECTROENCEPHALOGRAPHY	0	127,153	0.000000	0.000000	707 70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,763,478	0.000000	0.000000	53,842 71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	642,112	0.000000	0.000000	0 72.00
73.00	DRUGS CHARGED TO PATIENTS	0	5,898,754	0.000000	0.000000	366,651 73.00
74.00	RENAL DIALYSIS	0	0	0.000000	0.000000	0 74.00
75.00	ASC (NON-DISTINCT PART)	0	0	0.000000	0.000000	0 75.00
OUTPATIENT SERVICE COST CENTERS						
91.00	EMERGENCY	0	8,881,496	0.000000	0.000000	0 91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	995,408	0.000000	0.000000	0 92.00
200.00	Total (lines 50-199)	0	65,777,423			1,348,271 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151301

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

Worksheet D
Part IV
Date/Time Prepared:
1/26/2012 10:02 am

Cost Center Description	Title XIX			Hospital		
	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
	11.00	12.00	13.00	21.00	22.00	
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	0	0	0	0	50.00
51.00 RECOVERY ROOM	0	0	0	0	0	51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
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
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 LABORATORY	0	0	0	0	0	60.00
64.00 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 RESPIRATORY THERAPY	0	0	0	0	0	65.00
65.01 SLEEP LAB	0	0	0	0	0	65.01
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
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00 RENAL DIALYSIS	0	0	0	0	0	74.00
75.00 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS						
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: 151301	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part IV Date/Time Prepared: 1/26/2012 10:02 am
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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
51.00	RECOVERY ROOM	0	0			51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0			52.00
53.00	ANESTHESIOLOGY	0	0			53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0			54.00
55.00	RADIOLOGY-THERAPEUTIC	0	0			55.00
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
59.00	CARDIAC CATHETERIZATION	0	0			59.00
60.00	LABORATORY	0	0			60.00
64.00	INTRAVENOUS THERAPY	0	0			64.00
65.00	RESPIRATORY THERAPY	0	0			65.00
65.01	SLEEP LAB	0	0			65.01
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
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0			72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0			73.00
74.00	RENAL DIALYSIS	0	0			74.00
75.00	ASC (NON-DISTINCT PART)	0	0			75.00
OUTPATIENT SERVICE COST CENTERS						
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: 151301	Period: From 07/01/2010 To 06/30/2011	Worksheet D-1 Date/Time Prepared: 1/26/2012 10:02 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)		4,742	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		4,206	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)		4,206	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		209	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)		218	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		54	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)		55	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		2,024	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)		209	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)		218	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)		4,727,592	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)		8,237	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)		8,389	25.00
26.00	Total swing-bed cost (see instructions)		450,812	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		4,276,780	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		6,171,091	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		6,171,091	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.693035	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		1,467.21	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		4,276,780	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)		1,016.83	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,058,064	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		2,058,064	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151301

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

Worksheet D-1

Date/Time Prepared:
1/26/2012 10:02 am

Cost Center Description	Title XVIII			Hospital		Program Cost (col. 3 x col. 4)	
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days			
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT							43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description							
48.00 Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					1.00		
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,553,201		48.00
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)					212,517		64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					221,669		65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					434,186		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)					766		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,016.83		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					778,892		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151301		Period: From 07/01/2010 To 06/30/2011		Worksheet D-1 Date/Time Prepared: 1/26/2012 10:02 am	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 151301	Period: From 07/01/2010 To 06/30/2011	Worksheet D-1 Date/Time Prepared: 1/26/2012 10:02 am
	Title XIX	Hospital	Cost

Cost Center Description			1.00
PART I - ALL PROVIDER COMPONENTS			
INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,742	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,206	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)	4,206	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	209	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)	218	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	54	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)	55	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	571	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)	418	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)	432	15.00
16.00	Nursery days (title V or XIX only)	283	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)	4,727,592	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)	8,237	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)	8,389	25.00
26.00	Total swing-bed cost (see instructions)	450,812	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,276,780	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28.00	General inpatient routine service charges (excluding swing-bed charges)	6,171,091	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	6,171,091	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.693035	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	1,467.21	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	4,276,780	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)	1,016.83	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	580,610	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)	580,610	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 151301	Period: From 07/01/2010 To 06/30/2011	Worksheet D-1 Date/Time Prepared: 1/26/2012 10:02 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)	693,463	432	1,605.24	283	454,283	42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT						43.00
44.00 CORONARY CARE UNIT						44.00
45.00 BURN INTENSIVE CARE UNIT						45.00
46.00 SURGICAL INTENSIVE CARE UNIT						46.00
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						
48.00 Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					340,238	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,375,131	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)					425,035	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)					425,035	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)					766	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,016.83	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					778,892	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151301		Period: From 07/01/2010 To 06/30/2011		Worksheet D-1 Date/Time Prepared: 1/26/2012 10:02 am	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Hospital Total Observation Bed Cost (from line 89)	Cost Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151301	Period: From 07/01/2010 To 06/30/2011	Worksheet D-3	
		Title XVIII	Hospital	Date/Time Prepared: 1/26/2012 10:02 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		1,806,994		30.00
42.00	SUBPROVIDER		0		42.00
43.00	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.261928	435,652	114,109	50.00
51.00	RECOVERY ROOM	0.000000	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0.765427	0	0	52.00
53.00	ANESTHESIOLOGY	0.119124	26,884	3,203	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.265866	146,104	38,844	54.00
55.00	RADIOLOGY-THERAPEUTIC	0.000000	0	0	55.00
56.00	RADIOISOTOPE	0.000000	0	0	56.00
57.00	CT SCAN	0.037557	326,947	12,279	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.160176	73,204	11,726	58.00
59.00	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	LABORATORY	0.178095	928,056	165,282	60.00
64.00	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	RESPIRATORY THERAPY	0.466686	635,181	296,430	65.00
65.01	SLEEP LAB	0.192120	0	0	65.01
66.00	PHYSICAL THERAPY	0.367502	105,094	38,622	66.00
67.00	OCCUPATIONAL THERAPY	0.388753	48,623	18,902	67.00
68.00	SPEECH PATHOLOGY	1.545352	6,200	9,581	68.00
69.00	ELECTROCARDIOLOGY	0.241026	248,005	59,776	69.00
70.00	ELECTROENCEPHALOGRAPHY	0.061147	3,846	235	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.270246	641,984	173,494	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	1.210409	181,607	219,819	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.272098	1,425,532	387,884	73.00
74.00	RENAL DIALYSIS	0.000000	0	0	74.00
75.00	ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
OUTPATIENT SERVICE COST CENTERS					
91.00	EMERGENCY	0.373125	8,080	3,015	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.782485	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		5,240,999	1,553,201	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)		5,240,999		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151301	Period: From 07/01/2010 To 06/30/2011	Worksheet D-3
		Component CCN: 152301	Date/Time Prepared: 1/26/2012 10:02 am	
		Title XVIII	Swing Beds - SNF	Cost
Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
	1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS		154,308	30.00
42.00	SUBPROVIDER		0	42.00
43.00	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0.261928	1,961	50.00
51.00	RECOVERY ROOM	0.000000	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0.765427	0	52.00
53.00	ANESTHESIOLOGY	0.119124	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.265866	4,264	54.00
55.00	RADIOLOGY-THERAPEUTIC	0.000000	0	55.00
56.00	RADIOISOTOPE	0.000000	0	56.00
57.00	CT SCAN	0.037557	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.160176	0	58.00
59.00	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	LABORATORY	0.178095	6,427	60.00
64.00	INTRAVENOUS THERAPY	0.000000	0	64.00
65.00	RESPIRATORY THERAPY	0.466686	77,876	65.00
65.01	SLEEP LAB	0.192120	0	65.01
66.00	PHYSICAL THERAPY	0.367502	103,392	66.00
67.00	OCCUPATIONAL THERAPY	0.388753	36,767	67.00
68.00	SPEECH PATHOLOGY	1.545352	3,075	68.00
69.00	ELECTROCARDIOLOGY	0.241026	595	69.00
70.00	ELECTROENCEPHALOGRAPHY	0.061147	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.270246	48,491	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	1.210409	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.272098	193,702	73.00
74.00	RENAL DIALYSIS	0.000000	0	74.00
75.00	ASC (NON-DISTINCT PART)	0.000000	0	75.00
OUTPATIENT SERVICE COST CENTERS				
91.00	EMERGENCY	0.373125	1,112	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.782485	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		477,662	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)		477,662	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151301	Period: From 07/01/2010 To 06/30/2011	Worksheet D-3	
		Title XIX	Hospital	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS		1,467,931		30.00
42.00	SUBPROVIDER		0		42.00
43.00	NURSERY		0		43.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.261928	352,291	92,275	50.00
51.00	RECOVERY ROOM	0.000000	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0.765427	0	0	52.00
53.00	ANESTHESIOLOGY	0.119124	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.265866	40,980	10,895	54.00
55.00	RADIOLOGY-THERAPEUTIC	0.000000	0	0	55.00
56.00	RADIOISOTOPE	0.000000	0	0	56.00
57.00	CT SCAN	0.037557	54,869	2,061	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.160176	2,646	424	58.00
59.00	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	LABORATORY	0.178095	349,920	62,319	60.00
64.00	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	RESPIRATORY THERAPY	0.466686	114,279	53,332	65.00
65.01	SLEEP LAB	0.192120	0	0	65.01
66.00	PHYSICAL THERAPY	0.367502	3,994	1,468	66.00
67.00	OCCUPATIONAL THERAPY	0.388753	1,165	453	67.00
68.00	SPEECH PATHOLOGY	1.545352	753	1,164	68.00
69.00	ELECTROCARDIOLOGY	0.241026	6,174	1,488	69.00
70.00	ELECTROENCEPHALOGRAPHY	0.061147	707	43	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.270246	53,842	14,551	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	1.210409	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.272098	366,651	99,765	73.00
74.00	RENAL DIALYSIS	0.000000	0	0	74.00
75.00	ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
OUTPATIENT SERVICE COST CENTERS					
91.00	EMERGENCY	0.373125	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.782485	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		1,348,271	340,238	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)		1,348,271	0	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151301	Period: From 07/01/2010 To 06/30/2011	Worksheet E Part B Date/Time Prepared: 1/26/2012 10:02 am
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			4,019,541 1.00
2.00	Medical and other services reimbursed under OPPI (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)			4,019,541 11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges			0 12.00
13.00	Organ acquisition charges (from worksheet D-4, Part III, line 69, col. 4)			0 13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0 14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000 17.00
18.00	Total customary charges (see instructions)			0 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0 19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0 20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)			4,059,736 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)			46,568 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			2,523,948 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)			1,489,220 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)			1,489,220 30.00
31.00	Primary payer payments			822 31.00
32.00	Subtotal (line 30 minus line 31)			1,488,398 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)			544,473 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			544,473 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			456,667 36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)			2,032,871 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)			2,032,871 40.00
41.00	Interim payments			2,482,269 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)			-449,398 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: 151301	Period: From 07/01/2010 To 06/30/2011	Worksheet E Part B Date/Time Prepared: 1/26/2012 10:02 am
		Hospital	Cost
		Title XVIII	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: 151301		Period: From 07/01/2010 To 06/30/2011		Worksheet E-1 Part I Date/Time Prepared: 1/26/2012 10:02 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		3,567,182		2,976,778	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	01/27/2011	185,736	01/27/2011	26,360	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM	06/28/2011	643,144	06/28/2011	520,869	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		-457,408		-494,509	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)		3,109,774		2,482,269	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		174,020		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		449,398	6.02	
7.00	Total Medicare program liability (see instructions)		3,283,794		2,032,871	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: 151301	Period: From 07/01/2010 To 06/30/2011	Worksheet E-1 Part I Date/Time Prepared: 1/26/2012 10:02 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		614,005		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	01/27/2011	11,305		0
3.02			0		0
3.03			0		0
3.04			0		0
3.05			0		0
Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM	06/28/2011	19,198		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)		-7,893		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)		606,112		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		0		0
6.02	SETTLEMENT TO PROGRAM		7,739		0
7.00	Total Medicare program liability (see instructions)		598,373		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: 151301	Period: From 07/01/2010	Worksheet E-2
	Component CCN: 152301	To 06/30/2011	Date/Time Prepared: 1/26/2012 10:02 am

		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)	438,528		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)	164,172		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	427		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)	602,700		0	8.00
9.00	Primary payer payments (see instructions)	0		0	9.00
10.00	Subtotal (line 8 minus line 9)	602,700		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)	602,700		0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	4,327		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)	598,373		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)	598,373		0	19.00
20.00	Interim payments	606,112		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)	-7,739		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: 151301	Period: From 07/01/2010 To 06/30/2011	Worksheet E-3 Part V Date/Time Prepared: 1/26/2012 10:02 am
		Title XVIII	Hospital	Cost

PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHS)				
			1.00	
1.00	Inpatient services		3,611,265	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)		3,611,265	4.00
5.00	Primary payer payments		8,259	5.00
6.00	Total cost (line 5 less line 6) . For CAH (see instructions)		3,639,119	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)		3,639,119	19.00
20.00	Deductibles (exclude professional component)		446,232	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)		3,192,887	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		3,192,887	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		90,907	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		90,907	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		69,398	27.00
28.00	Subtotal (sum of lines 24 and 25 or 26(line 26 hospital and subprovider only))		3,283,794	28.00
29.00			0	29.00
29.99	Recovery of Accelerated Depreciation		0	29.99
30.00	Subtotal (line 28, plus or minus lines 29)		3,283,794	30.00
31.00	Interim payments		3,109,774	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)		174,020	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: 151301	Period: From 07/01/2010 To 06/30/2011	Worksheet E-3 Part VII Date/Time Prepared: 1/26/2012 10:02 am
		Title XIX	Hospital	Cost

PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		1,375,131	1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)		0	3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		1,375,131	4.00
5.00	Inpatient primary payer payments		0	5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		1,375,131	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges		0	8.00
9.00	Ancillary service charges		1,348,271	9.00
10.00	Organ acquisition charges, net of revenue		0	10.00
11.00	Incentive from target amount computation		0	11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		1,348,271	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)		1,348,271	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 7) (see instructions)		0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 7 exceeds line 16) (see instructions)		26,860	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)		1,375,131	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)		1,375,131	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		26,860	30.00
31.00	Subtotal (sum of lines 19 and 20, plus line 29 minus line 30)		1,348,271	31.00
32.00	Deductibles		0	32.00
33.00	Coinsurance		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Utilization review		0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		1,348,271	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	37.00
38.00	Subtotal (line 36 ± line 37)		1,348,271	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		1,348,271	40.00
41.00	Interim payments		1,348,271	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: 151301 Period: From 07/01/2010 To 06/30/2011 Worksheet G
 Date/Time Prepared: 1/26/2012 10:02 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	1,067,500	70,402	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	3,008,753	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	309,721	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	299,990	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)	4,685,964	70,402	0	0	11.00
FIXED ASSETS						
12.00	Land	721,752	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	18,028,712	0	0	0	15.00
16.00	Accumulated depreciation	0	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	5,715,823	0	0	0	19.00
20.00	Accumulated depreciation	-10,407,623	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)	14,058,664	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	18,590,881	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	52,713	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	18,643,594	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	37,388,222	70,402	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	3,535,078	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	1,075,151	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,610,229	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	14,632,397	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	311,358	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	14,943,755	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	19,553,984	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	17,834,238				52.00
53.00	Specific purpose fund		70,402			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)	17,834,238	70,402	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	37,388,222	70,402	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151301

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

Worksheet G-1

Date/Time Prepared:
1/26/2012 10:02 am

	General Fund		Special Purpose Fund			
	1.00	2.00	3.00	4.00		
1.00	Fund balances at beginning of period		8,634,729		146,672	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		6,226,495			2.00
3.00	Total (sum of line 1 and line 2)		14,861,224		146,672	3.00
4.00	CONTRIBUTIONS	0		25		4.00
5.00	NET INCOME NONCONTROLLING INT	14,161		0		5.00
6.00	TRANSFER FROM AFFILIATES	7,635		0		6.00
7.00	PROPERTY DONATIONS	98,414		0		7.00
8.00	DEFERRED PENSION COSTS	635,047		0		8.00
9.00	OTHER ACTIVITY	2,372,585		0		9.00
10.00	Total additions (sum of line 4-9)		3,127,842		25	10.00
11.00	Subtotal (line 3 plus line 10)		17,989,066		146,697	11.00
12.00	OTHER RESTRICTED ACTIVITY	154,829		76,295		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		154,829		76,295	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		17,834,237		70,402	19.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151301

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

Worksheet G-1

Date/Time Prepared:
1/26/2012 10:02 am

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES		Provider CCN: 151301	Period: From 07/01/2010 To 06/30/2011	Worksheet G-2 Parts
Cost Center Description		Inpatient	Outpatient	Total
		1.00	2.00	3.00
PART I - PATIENT REVENUES				
General Inpatient Routine Services				
1.00	Hospital	4,534,330		4,534,330
2.00	SUBPROVIDER - IPF			
3.00	SUBPROVIDER - IRF			
4.00	SUBPROVIDER	0		0
5.00	Swing bed - SNF	0		0
6.00	Swing bed - NF	0		0
7.00	SKILLED NURSING FACILITY			
8.00	NURSING FACILITY			
9.00	OTHER LONG TERM CARE			
10.00	Total general inpatient care services (sum of lines 1-9)	4,534,330		4,534,330
Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT			
12.00	CORONARY CARE UNIT			
13.00	BURN INTENSIVE CARE UNIT			
14.00	SURGICAL INTENSIVE CARE UNIT			
15.00	OTHER SPECIAL CARE (SPECIFY)			
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0
17.00	Total inpatient routine care services (sum of lines 10 and 16)	4,534,330		4,534,330
18.00	Ancillary services	11,514,695	58,730,359	70,245,054
19.00	Outpatient services	0	0	0
20.00	RURAL HEALTH CLINIC	0	0	0
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0
22.00	HOME HEALTH AGENCY		0	0
23.00	AMBULANCE SERVICES			
24.00	CMHC			
25.00	AMBULATORY SURGICAL CENTER (D.P.)			
26.00	HOSPICE	0	0	0
27.00	OTHER (SPECIFY)	0	0	0
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to wkst. G-3, line 1)	16,049,025	58,730,359	74,779,384
PART II - OPERATING EXPENSES				
29.00	Operating expenses (per wkst. A, column 3, line 200)		25,020,124	
30.00	BAD DEBT EXPENSE	4,555,380		
31.00		0		
32.00		0		
33.00		0		
34.00		0		
35.00		0		
36.00	Total additions (sum of lines 30-35)		4,555,380	
37.00	DEDUCT (SPECIFY)	0		
38.00		0		
39.00		0		
40.00		0		
41.00		0		
42.00	Total deductions (sum of lines 37-41)		0	
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to wkst. G-3, line 4)		29,575,504	

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 151301	Period: From 07/01/2010 To 06/30/2011	Worksheet G-3 Date/Time Prepared: 1/26/2012 10:02 am
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		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	74,779,384	1.00
2.00	Less contractual allowances and discounts on patients' accounts	41,497,690	2.00
3.00	Net patient revenues (line 1 minus line 2)	33,281,694	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	29,575,504	4.00
5.00	Net income from service to patients (line 3 minus line 4)	3,706,190	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and telegraph service	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	631,168	24.00
24.01	INTEREST INCOME	1,100,886	24.01
24.02	UNREALIZED GAIN - SHORT TERM	788,254	24.02
24.03		0	24.03
24.04		0	24.04
24.05		0	24.05
25.00	Total other income (sum of lines 6-24)	2,520,308	25.00
26.00	Total (line 5 plus line 25)	6,226,498	26.00
27.00	ROUNDING	3	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	3	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	6,226,495	29.00