

**ST. VINCENT SALEM HOSPITAL
SALEM, INDIANA**

PROVIDER NOS. 15-1314 AND 15-Z314

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

June 30, 2011

ST. VINCENT SALEM HOSPITAL
PROVIDER NOS. 15-1314 AND 15-Z314

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Accountants' Disclaimer

Hospital Statements of Reimbursable Costs



Board of Trustees
St. Vincent Salem Hospital
Salem, Indiana

In accordance with your request, we have compiled the Hospital Statements of Reimbursable Costs (Titles XVIII and XIX) of St. Vincent Salem Hospital (Provider Nos. 15-1314 and 15-Z314) for the year ended June 30, 2011 in the accompanying prescribed form in accordance with Statements on Standards for Accounting Review Services issued by the American Institute of Certified Public Accountants.

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

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

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

Bradley Associates

January 26, 2012

Board of Trustees
St. Vincent Salem Hospital
Salem, Indiana

In accordance with your request, we have compiled the Hospital Statements of Reimbursable Costs (Titles XVIII and XIX) of St. Vincent Salem Hospital (Provider Nos. 15-1314 and 15-Z314) 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.

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Bailey Associates

January 26, 2012

Health Financial Systems

In Lieu of Form CMS-2552-10

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY
 Provider CCN: 151314
 Period: From 07/01/2010 To 06/30/2011
 Worksheet S Parts I-III
 Date/Time Prepared: 1/27/2012 2:34 pm

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.

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.

Date: 1/27/2012 Time: 2:34 pm

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 SALEM 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: 1/27/2012 Time: 2:34 pm
 Eq6MVnsmaoxGu.RjgRhZurCz77u250
 2Rgtx0htRapOyuuM1s9jHyc5Bmb7i
 taM80eFgbG02fd2P
 PI: Date: 1/27/2012 Time: 2:34 pm
 u7Am2I7VE6pDEfEtt1cE2DIeeQdC0
 tugjw0UzY9dCLKTuGYzFESFQNTxx3.
 AEVFC6mOpD00as9H

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

 Title

 Date

	Title v 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-246,978	-68,498	0	11 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	-57,194	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	-304,172	-68,498	0	11 200.00

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: 151314		Period: From 07/01/2010 To 06/30/2011		Worksheet S-2 Part I Date/Time Prepared: 1/26/2012 10:06 am			
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 911 N. SHELBY STREET			PO Box:							
2.00	City: SALEM			State: IN		Zip Code: 47167		County: WASHINGTON			
				Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)		
									V	XVIII	XIX
				1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00
Hospital and Hospital-Based Component Identification:											
3.00	Hospital			ST VINCENT SALEM	151314	31140	1	12/01/2002	N	O	O
4.00	Subprovider - IPF										
5.00	Subprovider - IRF										
6.00	Subprovider - (Other)										
7.00	Swing Beds - SNF			ST VINCENT SALEM	152314	31140		12/01/2002	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										
13.00	Separately Certified ASC										
14.00	Hospital-Based Hospice										
15.00	Hospital-Based Health Clinic - RHC								N	N	N
16.00	Hospital-Based Health Clinic - FQHC								N	N	N
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	
21.00	Type of Control (see instructions)									2	
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	
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	
				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		
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		
								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	
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	
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	
								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.										
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	

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151314	Period: From 07/01/2010 To 06/30/2011	Worksheet S-2 Part I Date/Time Prepared: 1/26/2012 10:06 am			
		Beginning: 1.00	Ending: 2.00				
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.				38.00		
		V 1.00	XVIII 2.00	XIX 3.00			
Prospective Payment System (PPS)-Capital							
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00		
46.00	Is this facility eligible for the special exceptions payment pursuant to 42 CFR Section §412.348(g)? If yes, complete worksheet L, Part III and L-1, Parts I through III	N	N	N	46.00		
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00		
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00		
Teaching Hospitals							
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00		
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete worksheet E-4. If column 2 is "N", complete worksheet D, Part III & IV and D-2, Part II, if applicable.				57.00		
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete worksheet D-5.				58.00		
59.00	Are costs claimed on line 100 of worksheet A? If yes, complete worksheet D-2, Part I.	N			59.00		
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00		
		Y/N 1.00	IME Average 2.00	Direct GME Average 3.00			
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)	N	0.00	0.00	61.00		
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)							
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)		0.00		62.00		
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)		0.00		62.01		
Teaching Hospitals that Claim Residents in Non-Provider Settings							
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete lines 64-67. (see instructions)	N			63.00		
		Unweighted FTEs Nonprovider Site 1.00	Unweighted FTEs in Hospital 2.00	Ratio (col. 1/ (col. 1 + col. 2)) 3.00			
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 1.00	Program Code 2.00	Unweighted FTEs Nonprovider Site 3.00	Unweighted FTEs in Hospital 4.00	Ratio (col. 3/ (col. 3 + col. 4)) 5.00	
65.00	Enter in column 1 the program name. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151314	Period: From 07/01/2010 To 06/30/2011	Worksheet S-2 Part I Date/Time Prepared: 1/26/2012 10:06 am		
		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
				1.00	2.00	3.00
Inpatient Psychiatric Facility PPS						
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N		70.00
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)				0	71.00
Inpatient Rehabilitation Facility PPS						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N		75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)				0	76.00
				1.00		
Long Term Care Hospital PPS						
80.00	Is this a Long Term Care Hospital (LTCH)? Enter "Y" for yes or "N" for no.			N		80.00
TEFRA Providers						
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N		85.00
86.00	Did this facility establish a new other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			N		86.00
				V	XIX	
				1.00	2.00	
Title V or XIX Inpatient Services						
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.				Y	92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.				0.00	0.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.			N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.				0.00	0.00

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151314	Period: From 07/01/2010 To 06/30/2011	Worksheet S-2 Part I Date/Time Prepared: 1/26/2012 10:06 am	
		V.	XIX		
		1.00	2.00		
Rural Providers					
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?		Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)		N		106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)		N		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 1.00	Occupational 2.00	Speech 3.00	Respiratory 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		115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.		N		116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.		Y		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.			2	118.00
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	119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 as amended by the Medicaid Extender Act (MMEA) §108? Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with <= 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121? Enter in column 2 "Y" for yes or "N" for no.		N	N	120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.		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
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)		Y	15H046	140.00
		1.00	2.00	3.00	
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.					
141.00	Name: ST VINCENT HEALTH	Contractor's Name: NGS		Contractor's Number: 00130	
142.00	Street: 10330 N. MERIDIAN STREET	PO Box:			
143.00	City: INDIANAPOLIS	State: 18		Zip Code: 46290	
				1.00	
144.00	Are provider based physicians' costs included in worksheet A?		Y		144.00
145.00	If costs for renal services are claimed on worksheet A, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.		N		145.00

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151314		Period: From 07/01/2010 To 06/30/2011		Worksheet S-2 Part I Date/Time Prepared: 1/26/2012 10:06 am	
		1.00		2.00			
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N				146.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N				147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N				148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N				149.00	
		Part A 1.00		Part B 2.00			
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N		N		155.00	
156.00	Subprovider - IPF	N		N		156.00	
157.00	Subprovider - IRF	N		N		157.00	
158.00	Subprovider - Other	N		N		158.00	
159.00	SNF	N		N		159.00	
160.00	HHA	N		N		160.00	
161.00	CMHC			N		161.00	
				1.00			
Multicampus							
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.			N		165.00	
		Name 0	County 1.00	State 2.00	Zip Code 3.00	CBSA 4.00	FTE/Campus 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)					0 168.00	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)					0.00 169.00	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 151314	Period: From 07/01/2010 To 06/30/2011	Worksheet S-2 Part II Date/Time Prepared: 1/26/2012 10:06 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	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N	14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N	15.00
		Part A		
		Description	Y/N	Date
		0	1.00	2.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	10/12/2011	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

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HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 151314	Period: From 07/01/2010 To 06/30/2011	Worksheet S-2 Part II Date/Time Prepared: 1/26/2012 10:06 am
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	Description	Part A		
		Y/N	Date	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	2.00	21.00
				1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)				
Capital Related Cost				
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N		27.00
Interest Expense				
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	Y		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N		31.00
Purchased Services				
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N		33.00
Provider-Based Physicians				
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	Y		35.00
				Y/N
				Date
				1.00
				2.00
Home Office Costs				
36.00	Were home office costs claimed on the cost report?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 151314

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

Worksheet S-2
Part II
Date/Time Prepared:
1/26/2012 10:06 am

		Part B		
		Y/N	Date	
		3.00	4.00	
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	10/12/2011	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: 151314

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

Worksheet S-3
Part I
Date/Time Prepared:
1/26/2012 10:06 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	33,120.00	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	33,120.00	7.00
8.00 INTENSIVE CARE UNIT					8.00
9.00 CORONARY CARE UNIT					9.00
10.00 BURN INTENSIVE CARE UNIT					10.00
11.00 SURGICAL INTENSIVE CARE UNIT					11.00
12.00 OTHER SPECIAL CARE (SPECIFY)					12.00
13.00 NURSERY					13.00
14.00 Total (see instructions)		25	9,125	33,120.00	14.00
15.00 CAH visits					15.00
16.00 SUBPROVIDER - IPF					16.00
17.00 SUBPROVIDER - IRF					17.00
18.00 SUBPROVIDER					18.00
19.00 SKILLED NURSING FACILITY					19.00
20.00 NURSING FACILITY					20.00
21.00 OTHER LONG TERM CARE					21.00
22.00 HOME HEALTH AGENCY					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)					23.00
24.00 HOSPICE					24.00
25.00 CMHC - CMHC					25.00
26.00 RURAL HEALTH CLINIC	88.00				26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				26.25
27.00 Total (sum of lines 14-26)		25			27.00
28.00 Observation Bed Days					28.00
29.00 Ambulance Trips					29.00
30.00 Employee discount days (see instruction)					30.00
31.00 Employee discount days - IRF					31.00
32.00 Labor & delivery days (see instructions)					32.00
33.00 LTCH non-covered days					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151314

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

Worksheet S-3
Part I
Date/Time Prepared:
1/26/2012 10:06 am

Cost Center Description	I/P Days / O/P Visits / Trips				Total All Patients	
	Title V	Title XVIII	Title XIX			
	5.00	6.00	7.00	8.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	0	933	61	1,380	1.00	
2.00 HMO		0	0		2.00	
3.00 HMO IPF		0	0		3.00	
4.00 HMO IRF		0	0		4.00	
5.00 Hospital Adults & Peds. Swing Bed SNF	0	457	0	457	5.00	
6.00 Hospital Adults & Peds. Swing Bed NF	0		0	103	6.00	
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	0	1,390	61	1,940	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	1,390	61	1,940	14.00	
15.00 CAH visits	0	7,898	2,855	20,657	15.00	
16.00 SUBPROVIDER - IPF					16.00	
17.00 SUBPROVIDER - IRF					17.00	
18.00 SUBPROVIDER					18.00	
19.00 SKILLED NURSING FACILITY					19.00	
20.00 NURSING FACILITY					20.00	
21.00 OTHER LONG TERM CARE					21.00	
22.00 HOME HEALTH AGENCY					22.00	
23.00 AMBULATORY SURGICAL CENTER (D.P.)					23.00	
24.00 HOSPICE					24.00	
25.00 CMHC - CMHC					25.00	
26.00 RURAL HEALTH CLINIC	0	0	0	0	26.00	
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	26.25	
27.00 Total (sum of lines 14-26)					27.00	
28.00 Observation Bed Days	0		0	535	28.00	
29.00 Ambulance Trips		0			29.00	
30.00 Employee discount days (see instruction)				6	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: 151314	Period: From 07/01/2010 To 06/30/2011	Worksheet S-3 Part I Date/Time Prepared: 1/26/2012 10:06 am
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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	280	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	136.43	0.00	0	280	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0.00	0.00	0.00			26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00	0.00	0.00			26.25
27.00 Total (sum of lines 14-26)	0.00	136.43	0.00			27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151314

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

Worksheet S-3
Part I
Date/Time Prepared:
1/26/2012 10:06 am

Cost Center Description	Discharges			
	Title XIX	Total All Patients		
	14.00	15.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	25	440		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)	25	440		14.00
15.00 CAH visits				15.00
16.00 SUBPROVIDER - IPF				16.00
17.00 SUBPROVIDER - IRF				17.00
18.00 SUBPROVIDER				18.00
19.00 SKILLED NURSING FACILITY				19.00
20.00 NURSING FACILITY				20.00
21.00 OTHER LONG TERM CARE				21.00
22.00 HOME HEALTH AGENCY				22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)				23.00
24.00 HOSPICE				24.00
25.00 CMHC - CMHC				25.00
26.00 RURAL HEALTH CLINIC				26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER				26.25
27.00 Total (sum of lines 14-26)				27.00
28.00 Observation Bed Days				28.00
29.00 Ambulance Trips				29.00
30.00 Employee discount days (see instruction)				30.00
31.00 Employee discount days - IRF				31.00
32.00 Labor & delivery days (see instructions)				32.00
33.00 LTCH non-covered days				33.00

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HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 151314	Period: From 07/01/2010 To 06/30/2011	Worksheet S-10 Date/Time Prepared: 1/26/2012 10:06 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)		0.373143	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		1,279,526	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		N	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?			4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		0	5.00
6.00	Medicaid charges		8,739,931	6.00
7.00	Medicaid cost (line 1 times line 6)		3,261,244	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)		1,981,718	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		43,087	18.00
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		1,981,718	19.00
			1.00	
			2.00	
			3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	Uninsured patients	1,417,519	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	Insured patients	528,937	21.00
22.00	Partial payment by patients approved for charity care	Total (col. 1 + col. 2)	0	22.00
23.00	Cost of charity care (line 21 minus line 22)		528,937	23.00
			1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit		0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		4,491,498	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		744,787	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)		3,746,711	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)		1,398,059	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)		1,926,996	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		3,908,714	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151314

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

Worksheet A

Date/Time Prepared:
1/26/2012 10:06 am

Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassification 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		418,766	418,766	4,928	423,694	1.00
2.00 CAP REL COSTS-MVBLE EQUIP		0	0	13,881	13,881	2.00
3.00 OTHER CAP RELATED COST		18,809	18,809	-18,809	0	3.00
4.00 EMPLOYEE BENEFITS	180,018	2,023,286	2,203,304	0	2,203,304	4.00
5.00 ADMINISTRATIVE & GENERAL	1,255,845	1,189,872	2,445,717	0	2,445,717	5.00
7.00 OPERATION OF PLANT	179,878	1,219,650	1,399,528	0	1,399,528	7.00
8.00 LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00 HOUSEKEEPING	145,005	34,981	179,986	0	179,986	9.00
10.00 DIETARY	196,013	86,679	282,692	-210,163	72,529	10.00
11.00 CAFETERIA	0	0	0	210,163	210,163	11.00
13.00 NURSING ADMINISTRATION	45,199	-136	45,063	0	45,063	13.00
14.00 CENTRAL SERVICES & SUPPLY	87,675	10,436	98,111	0	98,111	14.00
15.00 PHARMACY	198,169	55,501	253,670	0	253,670	15.00
16.00 MEDICAL RECORDS & LIBRARY	251,306	25,941	277,247	0	277,247	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	901,916	65,872	967,788	0	967,788	30.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	636,922	607,472	1,244,394	0	1,244,394	50.00
54.00 RADIOLOGY - DIAGNOSTIC	577,809	394,694	972,503	0	972,503	54.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	53,822	345,202	399,024	0	399,024	58.00
60.00 LABORATORY	70,032	1,493,115	1,563,147	0	1,563,147	60.00
61.00 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0	0	0	0	61.00
65.00 RESPIRATORY THERAPY	233,924	21,141	255,065	0	255,065	65.00
66.00 PHYSICAL THERAPY	387,125	14,485	401,610	0	401,610	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	194,087	8,202	202,289	0	202,289	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	250,072	250,072	0	250,072	71.00
72.00 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	337,961	337,961	0	337,961	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	309,186	309,186	0	309,186	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
75.01 SLEEP DISORDER	140,562	73,747	214,309	0	214,309	75.01
75.02 NEW HORIZON OP	23,070	382	23,452	0	23,452	75.02
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 CLINIC	0	0	0	0	0	90.00
91.00 EMERGENCY	1,653,223	235,637	1,888,860	0	1,888,860	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1-117)	7,411,600	9,240,953	16,652,553	0	16,652,553	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP, & CANTÉEN	0	0	0	0	0	190.00
191.00 RESEARCH	0	0	0	0	0	191.00
192.00 PHYSICIANS' PRIVATE OFFICES	72,043	9,101	81,144	0	81,144	192.00
193.00 NONPAID WORKERS	0	0	0	0	0	193.00
193.01 MARKETING/ PUBLIC RELATIONS	54,862	5,796	60,658	0	60,658	193.01
200.00 TOTAL (SUM OF LINES 118-199)	7,538,505	9,255,850	16,794,355	0	16,794,355	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151314

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

Worksheet A

Date/Time Prepared:
1/26/2012 10:06 am

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	190,463	614,157	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	13,881	2.00
3.00	OTHER CAP RELATED COST	0	0	3.00
4.00	EMPLOYEE BENEFITS	124,200	2,327,504	4.00
5.00	ADMINISTRATIVE & GENERAL	1,384,911	3,830,628	5.00
7.00	OPERATION OF PLANT	-23,701	1,375,827	7.00
8.00	LAUNDRY & LINEN SERVICE	0	0	8.00
9.00	HOUSEKEEPING	0	179,986	9.00
10.00	DIETARY	0	72,529	10.00
11.00	CAFETERIA	-62,013	148,150	11.00
13.00	NURSING ADMINISTRATION	0	45,063	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	98,111	14.00
15.00	PHARMACY	0	253,670	15.00
16.00	MEDICAL RECORDS & LIBRARY	-6,852	270,395	16.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	-24,100	943,688	30.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	-45,097	1,199,297	50.00
54.00	RADIOLOGY - DIAGNOSTIC	-199,394	773,109	54.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	399,024	58.00
60.00	LABORATORY	0	1,563,147	60.00
61.00	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0	61.00
65.00	RESPIRATORY THERAPY	0	255,065	65.00
66.00	PHYSICAL THERAPY	0	401,610	66.00
67.00	OCCUPATIONAL THERAPY	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	202,289	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	250,072	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	337,961	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	309,186	73.00
74.00	RENAL DIALYSIS	0	0	74.00
75.00	ASC (NON-DISTINCT PART)	0	0	75.00
75.01	SLEEP DISORDER	-51,600	162,709	75.01
75.02	NEW HORIZON OP	0	23,452	75.02
OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	CLINIC	0	0	90.00
91.00	EMERGENCY	-568,927	1,319,933	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
SPECIAL PURPOSE COST CENTERS				
118.00	SUBTOTALS (SUM OF LINES 1-117)	717,890	17,370,443	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	81,144	192.00
193.00	NONPAID WORKERS	0	0	193.00
193.01	MARKETING/ PUBLIC RELATIONS	227,996	288,654	193.01
200.00	TOTAL (SUM OF LINES 118-199)	945,886	17,740,241	200.00

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RECLASSIFICATIONS

Provider CCN: 151314

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

Worksheet A-6

Date/Time Prepared:
1/26/2012 10:06 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
A - CAFETERIA					
1.00	CAFETERIA	11.00	145,723	64,440	1.00
	TOTALS		145,723	64,440	
500.00	Grand Total: Increases		145,723	64,440	500.00

RECLASSIFICATIONS

Provider CCN: 151314

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

Worksheet A-6

Date/Time Prepared:
1/26/2012 10:06 am

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	145,723	64,440	0		1.00
TOTALS			145,723	64,440			
500.00	Grand Total: Decreases		145,723	64,440			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151314

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
1/26/2012 10:06 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	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	2.00
3.00	Buildings and Fixtures	70,893	17,216	0	17,216	3.00
4.00	Building Improvements	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	5.00
6.00	Movable Equipment	146,830	101,359	0	101,359	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	217,723	118,575	0	118,575	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	217,723	118,575	0	118,575	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	0	418,766	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	418,766	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	88,109	0	88,109	0.261997	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	248,189	0	248,189	0.738003	2.00
3.00	Total (sum of lines 1-2)	336,298	0	336,298	1.000000	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151314

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
1/26/2012 10:06 am

		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES.							
1.00	Land	0	0		1.00		
2.00	Land Improvements	0	0		2.00		
3.00	Buildings and Fixtures	88,109	0		3.00		
4.00	Building Improvements	0	0		4.00		
5.00	Fixed Equipment	0	0		5.00		
6.00	Movable Equipment	248,189	0		6.00		
7.00	HIT designated Assets	0	0		7.00		
8.00	Subtotal (sum of lines 1-7)	336,298	0		8.00		
9.00	Reconciling Items	0	0		9.00		
10.00	Total (line 8 minus line 9)	336,298	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	418,766		1.00		
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		2.00		
3.00	Total (sum of lines 1-2)	0	418,766		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	4,928	190,463	418,766	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	13,881	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	18,809	190,463	418,766	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS	Provider CCN: 151314	Period: From 07/01/2010 To 06/30/2011	Worksheet A-7 Parts I-III Date/Time Prepared: 1/26/2012 10:06 am
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Cost Center Description	SUMMARY OF CAPITAL						
	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)		
	11.00	12.00	13.00	14.00	15.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	4,928	0	0	614,157	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	13,881	0	0	13,881	2.00
3.00	Total (sum of lines 1-2)	0	18,809	0	0	628,038	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 151314

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

Worksheet A-8

Date/Time Prepared:
1/26/2012 10:06 am

		Basis/Code (2)	Amount	Expense Classification on worksheet A To/From Which the Amount is to be Adjusted	
				Cost Center	Line #
				1.00	2.00
1.00	Investment income - buildings and fixtures (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00 1.00
2.00	Investment income - movable equipment (chapter 2)		0	CAP 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	-888,053		10.00 10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00 11.00
12.00	Related organization transactions (chapter 10)	A-8-1	1,881,731		12.00 12.00
13.00	Laundry and linen service		0		0.00 13.00
14.00	Cafeteria-employees and guests	B	-62,013	CAFETERIA	11.00 14.00
15.00	Rental of quarters to employee and others		0		0.00 15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00 16.00
17.00	Sale of drugs to other than patients		0		0.00 17.00
18.00	Sale of medical records and abstracts	B	-20,131	MEDICAL RECORDS & LIBRARY	16.00 18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00 19.00
20.00	Vending machines		0		0.00 20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00 21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00 22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00 23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00 24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00 25.00
26.00	Depreciation - buildings and fixtures		0	CAP REL COSTS-BLDG & FIXT	1.00 26.00
27.00	Depreciation - movable equipment		0	CAP REL COSTS-MVBLE EQUIP	2.00 27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00 28.00
29.00	Physicians' assistant		0		0.00 29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00 30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00 31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00 32.00
33.00	OTHER REVENUE - RADIOLOGY	B	-1,065	RADIOLOGY - DIAGNOSTIC	54.00 33.00
33.01	OTHER REVENUE - ADMINISTRATION	B	-2,000	ADMINISTRATIVE & GENERAL	5.00 33.01
33.02	ASSOCIATION DUES LOBBYING EXPENSE OF	A	-1,417	ADMINISTRATIVE & GENERAL	5.00 33.02
33.03	CSI SERVICE FEE (COLLECTION AGENCY)	A	17,944	ADMINISTRATIVE & GENERAL	5.00 33.03
33.04	MED RECORDS FOR SPN	A	13,279	MEDICAL RECORDS & LIBRARY	16.00 33.04
33.05	NONALLOWABLE EXPENSES	A	-10	ADMINISTRATIVE & GENERAL	5.00 33.05
33.06	INCENTIVE ADJUSTMENT - SALARY	A	7,621	ADMINISTRATIVE & GENERAL	5.00 33.06
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200.)		945,886		50.00 50.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 151314

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

Worksheet A-8

Date/Time Prepared:
1/26/2012 10:06 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)		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		25.00
26.00	Depreciation - buildings and fixtures	0	26.00
27.00	Depreciation - movable equipment	0	27.00
28.00	Non-physician Anesthetist		28.00
29.00	Physicians' assistant	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)		30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	0	32.00
33.00	OTHER REVENUE - RADIOLOGY	0	33.00
33.01	OTHER REVENUE - ADMINISTRATION	0	33.01
33.02	ASSOCIATION DUES LOBBYING EXPENSE OF	0	33.02
33.03	CSI SERVICE FEE (COLLECTION AGENCY)	0	33.03
33.04	MED RECORDS FOR SPN	0	33.04
33.05	NONALLOWABLE EXPENSES	0	33.05
33.06	INCENTIVE ADJUSTMENT - SALARY	0	33.06
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200.)		50.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151314

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

Worksheet A-8-2

Date/Time Prepared:
1/26/2012 10:06 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
	1.00	2.00	3.00	4.00	
1.00	91.00	ER	1,042,679	568,927	1.00
2.00	13.00	STAFF DEVELOPMENT	30	0	2.00
3.00	30.00	MEDICAL/SURGICAL	24,100	24,100	3.00
4.00	50.00	SURGERY	45,097	45,097	4.00
5.00	54.00	RADIOLOGY	288,611	198,329	5.00
6.00	60.00	LAB	38,910	0	6.00
7.00	75.01	SLEEP DISORDER	51,600	51,600	7.00
8.00	0.00		0	0	8.00
9.00	0.00		0	0	9.00
10.00	0.00		0	0	10.00
200.00		TOTAL (lines 1.00 through 199.00)	1,491,027	888,053	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151314

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

Worksheet A-8-2

Date/Time Prepared:
1/26/2012 10:06 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	473,752	0	0	0	0	1.00
2.00	30	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	90,282	0	0	0	0	5.00
6.00	38,910	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	602,974					200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151314

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

Worksheet A-8-2

Date/Time Prepared:
1/26/2012 10:06 am

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151314

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

Worksheet A-8-2

Date/Time Prepared:
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	RCE	Adjustment	
	Disallowance		
	17.00	18.00	
1.00	0	568,927	1.00
2.00	0	0	2.00
3.00	0	24,100	3.00
4.00	0	45,097	4.00
5.00	0	198,329	5.00
6.00	0	0	6.00
7.00	0	51,600	7.00
8.00	0	0	8.00
9.00	0	0	9.00
10.00	0	0	10.00
200.00	0	888,053	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151314

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

Worksheet B
Part I
Date/Time Prepared:
1/26/2012 10:06 am

Cost Center Description	Net Expenses for Cost Allocation (from wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	614,157	614,157			1.00
2.00	CAP REL COSTS-MVBLE EQUIP	13,881		13,881		2.00
4.00	EMPLOYEE BENEFITS	2,327,504	0	0	2,327,504	4.00
5.00	ADMINISTRATIVE & GENERAL	3,830,628	101,254	2,286	398,895	4,333,063
7.00	OPERATION OF PLANT	1,375,827	39,158	885	57,461	1,473,331
8.00	LAUNDRY & LINEN SERVICE	0	17,593	398	0	17,991
9.00	HOUSEKEEPING	179,986	2,550	58	46,058	228,652
10.00	DIETARY	72,529	50,927	1,151	15,974	140,581
11.00	CAFETERIA	148,150	0	0	46,286	194,436
13.00	NURSING ADMINISTRATION	45,063	1,779	40	14,357	61,239
14.00	CENTRAL SERVICES & SUPPLY	98,111	14,555	329	27,848	140,843
15.00	PHARMACY	253,670	0	0	52,837	306,507
16.00	MEDICAL RECORDS & LIBRARY	270,395	8,918	202	79,823	359,338
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	943,688	82,499	1,865	286,476	1,314,528
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	1,199,297	75,351	1,703	202,306	1,478,657
54.00	RADIOLOGY - DIAGNOSTIC	773,109	33,350	754	183,530	990,743
58.00	MAGNETIC RESONANCE IMAGING (MRI)	399,024	7,538	170	17,096	423,828
60.00	LABORATORY	1,563,147	17,203	389	22,244	1,602,983
61.00	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0	0	0	0
65.00	RESPIRATORY THERAPY	255,065	0	0	74,302	329,367
66.00	PHYSICAL THERAPY	401,610	14,970	338	122,963	539,881
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	SPEECH PATHOLOGY	0	0	0	0	0
69.00	ELECTROCARDIOLOGY	202,289	13,443	304	61,648	277,684
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	250,072	0	0	0	250,072
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	337,961	0	0	0	337,961
73.00	DRUGS CHARGED TO PATIENTS	309,186	861	19	0	310,066
74.00	RENAL DIALYSIS	0	0	0	0	0
75.00	ASC (NON-DISTINCT PART)	0	0	0	0	0
75.01	SLEEP DISORDER	162,709	9,113	206	44,647	216,675
75.02	NEW HORIZON OP	23,452	6,750	153	7,328	37,683
OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	0	0	0
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00	CLINIC	0	0	0	0	0
91.00	EMERGENCY	1,319,933	37,233	842	525,116	1,883,124
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	17,370,443	535,045	12,092	2,287,195	17,249,233
NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	2,104	48	0	2,152
191.00	RESEARCH	0	0	0	0	0
192.00	PHYSICIANS' PRIVATE OFFICES	81,144	70,023	1,583	22,883	175,633
193.00	NONPAID WORKERS	0	0	0	0	0
193.01	MARKETING/ PUBLIC RELATIONS	288,654	6,985	158	17,426	313,223
200.00	Cross Foot Adjustments	0	0	0	0	0
201.00	Negative Cost Centers	0	0	0	0	0
202.00	TOTAL (sum lines 118-201)	17,740,241	614,157	13,881	2,327,504	17,740,241

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151314

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

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	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	4,333,063					5.00
7.00	OPERATION OF PLANT	476,166	1,949,497				7.00
8.00	LAUNDRY & LINEN SERVICE	5,815	72,397	96,203			8.00
9.00	HOUSEKEEPING	73,898	10,495	3,291	316,336		9.00
10.00	DIETARY	45,434	209,569	3,544	0	399,128	10.00
11.00	CAFETERIA	62,840	0	0	501	0	11.00
13.00	NURSING ADMINISTRATION	19,792	7,320	0	0	0	13.00
14.00	CENTRAL SERVICES & SUPPLY	45,519	59,896	0	4,171	0	14.00
15.00	PHARMACY	99,060	0	0	0	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	116,134	36,700	0	5,673	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	424,842	339,488	28,198	86,258	399,128	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	477,887	310,076	16,305	83,922	0	50.00
54.00	RADIOLOGY - DIAGNOSTIC	320,198	137,240	8,812	18,520	0	54.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	136,977	31,018	0	0	0	58.00
60.00	LABORATORY	518,068	70,792	0	12,847	0	60.00
61.00	PBP CLINICAL LAB. SERVICE-PRGM. ONLY						61.00
65.00	RESPIRATORY THERAPY	106,448	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	174,484	61,601	6,753	9,677	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	89,745	55,317	1,751	12,346	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	80,821	0	0	0	0	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	109,226	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	100,210	3,543	0	5,339	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
75.01	SLEEP DISORDER	70,027	37,502	2,335	7,341	0	75.01
75.02	NEW HORIZON OP	12,179	27,775	0	0	0	75.02
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	0	0	0	0	0	90.00
91.00	EMERGENCY	608,603	153,216	24,984	57,227	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	4,174,373	1,623,945	95,973	303,822	399,128	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	696	8,657	0	2,670	0	190.00
191.00	RESEARCH	0	0	0	0	0	191.00
192.00	PHYSICIANS' PRIVATE OFFICES	56,763	288,150	230	9,844	0	192.00
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	MARKETING/ PUBLIC RELATIONS	101,231	28,745	0	0	0	193.01
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)	4,333,063	1,949,497	96,203	316,336	399,128	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151314

Period:
From 07/01/2010
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Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
	11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS						
1.00						1.00
2.00						2.00
4.00						4.00
5.00						5.00
7.00						7.00
8.00						8.00
9.00						9.00
10.00						10.00
11.00	257,777					11.00
13.00	3,125	91,476				13.00
14.00	7,189	0	257,618			14.00
15.00	5,585	0	0	411,152		15.00
16.00	19,717	0	0	0	537,562	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	48,963	16,262	0	0	64,724	30.00
ANCILLARY SERVICE COST CENTERS						
50.00	28,374	13,552	0	0	101,931	50.00
54.00	30,984	12,874	0	0	121,698	54.00
58.00	2,567	0	0	0	0	58.00
60.00	3,948	7,454	0	0	0	60.00
61.00						61.00
65.00	12,723	7,454	0	0	0	65.00
66.00	17,546	10,842	0	0	0	66.00
67.00	0	0	0	0	0	67.00
68.00	0	0	0	0	0	68.00
69.00	11,207	0	0	0	0	69.00
70.00	0	0	0	0	0	70.00
71.00	0	0	252,798	0	0	71.00
72.00	0	0	4,820	0	0	72.00
73.00	0	8,131	0	411,152	0	73.00
74.00	0	0	0	0	0	74.00
75.00	0	0	0	0	0	75.00
75.01	8,783	0	0	0	0	75.01
75.02	1,375	0	0	0	0	75.02
OUTPATIENT SERVICE COST CENTERS						
88.00	0	0	0	0	0	88.00
89.00	0	0	0	0	0	89.00
90.00	0	0	0	0	0	90.00
91.00	47,960	14,907	0	0	127,124	91.00
92.00						92.00
SPECIAL PURPOSE COST CENTERS						
118.00	250,046	91,476	257,618	411,152	415,477	118.00
NONREIMBURSABLE COST CENTERS						
190.00	0	0	0	0	0	190.00
191.00	0	0	0	0	0	191.00
192.00	4,966	0	0	0	122,085	192.00
193.00	0	0	0	0	0	193.00
193.01	2,765	0	0	0	0	193.01
200.00						200.00
201.00	0	0	0	0	0	201.00
202.00	257,777	91,476	257,618	411,152	537,562	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151314

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

Worksheet B
Part I
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Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00 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
7.00 OPERATION OF PLANT				7.00
8.00 LAUNDRY & LINEN SERVICE				8.00
9.00 HOUSEKEEPING				9.00
10.00 DIETARY				10.00
11.00 CAFETERIA				11.00
13.00 NURSING ADMINISTRATION				13.00
14.00 CENTRAL SERVICES & SUPPLY				14.00
15.00 PHARMACY				15.00
16.00 MEDICAL RECORDS & LIBRARY				16.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00 ADULTS & PEDIATRICS	2,722,391	0	2,722,391	30.00
ANCILLARY SERVICE COST CENTERS				
50.00 OPERATING ROOM	2,510,704	0	2,510,704	50.00
54.00 RADIOLOGY - DIAGNOSTIC	1,641,069	0	1,641,069	54.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	594,390	0	594,390	58.00
60.00 LABORATORY	2,216,092	0	2,216,092	60.00
61.00 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0	0	61.00
65.00 RESPIRATORY THERAPY	455,992	0	455,992	65.00
66.00 PHYSICAL THERAPY	820,784	0	820,784	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	448,050	0	448,050	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	583,691	0	583,691	71.00
72.00 IMPLANTABLE DEVICES CHARGED TO PATIENTS	452,007	0	452,007	72.00
73.00 DRUGS CHARGED TO PATIENTS	838,441	0	838,441	73.00
74.00 RENAL DIALYSIS	0	0	0	74.00
75.00 ASC (NON-DISTINCT PART)	0	0	0	75.00
75.01 SLEEP DISORDER	342,663	0	342,663	75.01
75.02 NEW HORIZON OP	79,012	0	79,012	75.02
OUTPATIENT SERVICE COST CENTERS				
88.00 RURAL HEALTH CLINIC	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00 CLINIC	0	0	0	90.00
91.00 EMERGENCY	2,917,145	0	2,917,145	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS				
118.00 SUBTOTALS (SUM OF LINES 1-117)	16,622,431	0	16,622,431	118.00
NONREIMBURSABLE COST CENTERS				
190.00 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	14,175	0	14,175	190.00
191.00 RESEARCH	0	0	0	191.00
192.00 PHYSICIANS' PRIVATE OFFICES	657,671	0	657,671	192.00
193.00 NONPAID WORKERS	0	0	0	193.00
193.01 MARKETING/ PUBLIC RELATIONS	445,964	0	445,964	193.01
200.00 Cross Foot Adjustments	0	0	0	200.00
201.00 Negative Cost Centers	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	17,740,241	0	17,740,241	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151314

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

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00	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	0	101,254	2,286	103,540	5.00
7.00	OPERATION OF PLANT	0	39,158	885	40,043	7.00
8.00	LAUNDRY & LINEN SERVICE	0	17,593	398	17,991	8.00
9.00	HOUSEKEEPING	0	2,550	58	2,608	9.00
10.00	DIETARY	0	50,927	1,151	52,078	10.00
11.00	CAFETERIA	0	0	0	0	11.00
13.00	NURSING ADMINISTRATION	0	1,779	40	1,819	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	14,555	329	14,884	14.00
15.00	PHARMACY	0	0	0	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	0	8,918	202	9,120	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	0	82,499	1,865	84,364	30.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	75,351	1,703	77,054	50.00
54.00	RADIOLOGY - DIAGNOSTIC	0	33,350	754	34,104	54.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	7,538	170	7,708	58.00
60.00	LABORATORY	0	17,203	389	17,592	60.00
61.00	PBP CLINICAL LAB. SERVICE-PRGM. ONLY				0	61.00
65.00	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	14,970	338	15,308	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	13,443	304	13,747	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	861	19	880	73.00
74.00	RENAL DIALYSIS	0	0	0	0	74.00
75.00	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
75.01	SLEEP DISORDER	0	9,113	206	9,319	75.01
75.02	NEW HORIZON OP	0	6,750	153	6,903	75.02
OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	CLINIC	0	0	0	0	90.00
91.00	EMERGENCY	0	37,233	842	38,075	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)				0	92.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	535,045	12,092	547,137	118.00
NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	2,104	48	2,152	190.00
191.00	RESEARCH	0	0	0	0	191.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	70,023	1,583	71,606	192.00
193.00	NONPAID WORKERS	0	0	0	0	193.00
193.01	MARKETING/ PUBLIC RELATIONS	0	6,985	158	7,143	193.01
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	614,157	13,881	628,038	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151314

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

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	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	103,540					5.00
7.00	OPERATION OF PLANT	11,379	51,422				7.00
8.00	LAUNDRY & LINEN SERVICE	139	1,910	20,040			8.00
9.00	HOUSEKEEPING	1,766	277	686	5,337		9.00
10.00	DIETARY	1,086	5,528	738	0	59,430	10.00
11.00	CAFETERIA	1,502	0	0	8	0	11.00
13.00	NURSING ADMINISTRATION	473	193	0	0	0	13.00
14.00	CENTRAL SERVICES & SUPPLY	1,088	1,580	0	70	0	14.00
15.00	PHARMACY	2,367	0	0	0	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	2,775	968	0	96	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	10,152	8,955	5,874	1,456	59,430	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	11,420	8,179	3,396	1,416	0	50.00
54.00	RADIOLOGY - DIAGNOSTIC	7,652	3,620	1,836	312	0	54.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	3,273	818	0	0	0	58.00
60.00	LABORATORY	12,380	1,867	0	217	0	60.00
61.00	PBP CLINICAL LAB. SERVICE-PRGM. ONLY						61.00
65.00	RESPIRATORY THERAPY	2,544	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	4,170	1,625	1,407	163	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	2,145	1,459	365	208	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,931	0	0	0	0	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	2,610	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	2,395	93	0	90	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
75.01	SLEEP DISORDER	1,673	989	486	124	0	75.01
75.02	NEW HORIZON OP	291	733	0	0	0	75.02
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	0	0	0	0	0	90.00
91.00	EMERGENCY	14,537	4,041	5,204	966	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	99,748	42,835	19,992	5,126	59,430	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	17	228	0	45	0	190.00
191.00	RESEARCH	0	0	0	0	0	191.00
192.00	PHYSICIANS' PRIVATE OFFICES	1,356	7,601	48	166	0	192.00
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	MARKETING/ PUBLIC RELATIONS	2,419	758	0	0	0	193.01
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)	103,540	51,422	20,040	5,337	59,430	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151314

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

Worksheet B
Part II
Date/Time Prepared:
1/26/2012 10:06 am

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	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
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	1,510					11.00
13.00	NURSING ADMINISTRATION	18	2,503				13.00
14.00	CENTRAL SERVICES & SUPPLY	42	0	17,664			14.00
15.00	PHARMACY	33	0	0	2,400		15.00
16.00	MEDICAL RECORDS & LIBRARY	116	0	0	0	13,075	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	286	445	0	0	1,574	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	166	371	0	0	2,479	50.00
54.00	RADIOLOGY - DIAGNOSTIC	182	352	0	0	2,960	54.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	15	0	0	0	0	58.00
60.00	LABORATORY	23	204	0	0	0	60.00
61.00	PBP CLINICAL LAB. SERVICE-PRGM. ONLY						61.00
65.00	RESPIRATORY THERAPY	75	204	0	0	0	65.00
66.00	PHYSICAL THERAPY	103	297	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	66	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	17,333	0	0	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	331	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	222	0	2,400	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
75.01	SLEEP DISORDER	51	0	0	0	0	75.01
75.02	NEW HORIZON OP	8	0	0	0	0	75.02
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	0	0	0	0	0	90.00
91.00	EMERGENCY	281	408	0	0	3,093	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	1,465	2,503	17,664	2,400	10,106	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	29	0	0	0	2,969	192.00
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	MARKETING/ PUBLIC RELATIONS	16	0	0	0	0	193.01
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)	1,510	2,503	17,664	2,400	13,075	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151314

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

Worksheet B
Part II
Date/Time Prepared:
1/26/2012 10:06 am

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	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
7.00	OPERATION OF PLANT				7.00
8.00	LAUNDRY & LINEN SERVICE				8.00
9.00	HOUSEKEEPING				9.00
10.00	DIETARY				10.00
11.00	CAFETERIA				11.00
13.00	NURSING ADMINISTRATION				13.00
14.00	CENTRAL SERVICES & SUPPLY				14.00
15.00	PHARMACY				15.00
16.00	MEDICAL RECORDS & LIBRARY				16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS	172,536	0	172,536	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	104,481	0	104,481	50.00
54.00	RADIOLOGY - DIAGNOSTIC	51,018	0	51,018	54.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	11,814	0	11,814	58.00
60.00	LABORATORY	32,283	0	32,283	60.00
61.00	PBP CLINICAL LAB. SERVICE-PRGM. ONLY				61.00
65.00	RESPIRATORY THERAPY	2,823	0	2,823	65.00
66.00	PHYSICAL THERAPY	23,073	0	23,073	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	17,990	0	17,990	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	19,264	0	19,264	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	2,941	0	2,941	72.00
73.00	DRUGS CHARGED TO PATIENTS	6,080	0	6,080	73.00
74.00	RENAL DIALYSIS	0	0	0	74.00
75.00	ASC (NON-DISTINCT PART)	0	0	0	75.00
75.01	SLEEP DISORDER	12,642	0	12,642	75.01
75.02	NEW HORIZON OP	7,935	0	7,935	75.02
OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00	CLINIC	0	0	0	90.00
91.00	EMERGENCY	66,605	0	66,605	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
SPECIAL PURPOSE COST CENTERS					
118.00	SUBTOTALS (SUM OF LINES 1-117)	531,485	0	531,485	118.00
NONREIMBURSABLE COST CENTERS					
190.00	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	2,442	0	2,442	190.00
191.00	RESEARCH	0	0	0	191.00
192.00	PHYSICIANS' PRIVATE OFFICES	83,775	0	83,775	192.00
193.00	NONPAID WORKERS	0	0	0	193.00
193.01	MARKETING/ PUBLIC RELATIONS	10,336	0	10,336	193.01
200.00	Cross Foot Adjustments	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	628,038	0	628,038	202.00

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. 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	75,613					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		75,613				2.00
4.00	EMPLOYEE BENEFITS	0	0	7,327,692			4.00
5.00	ADMINISTRATIVE & GENERAL	12,466	12,466	1,255,845	-4,333,063	13,407,178	5.00
7.00	OPERATION OF PLANT	4,821	4,821	180,904	0	1,473,331	7.00
8.00	LAUNDRY & LINEN SERVICE	2,166	2,166	0	0	17,991	8.00
9.00	HOUSEKEEPING	314	314	145,005	0	228,652	9.00
10.00	DIETARY	6,270	6,270	50,290	0	140,581	10.00
11.00	CAFETERIA	0	0	145,723	0	194,436	11.00
13.00	NURSING ADMINISTRATION	219	219	45,199	0	61,239	13.00
14.00	CENTRAL SERVICES & SUPPLY	1,792	1,792	87,675	0	140,843	14.00
15.00	PHARMACY	0	0	166,348	0	306,507	15.00
16.00	MEDICAL RECORDS & LIBRARY	1,098	1,098	251,306	0	359,338	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	10,157	10,157	901,916	0	1,314,528	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	9,277	9,277	636,922	0	1,478,657	50.00
54.00	RADIOLOGY - DIAGNOSTIC	4,106	4,106	577,809	0	990,743	54.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	928	928	53,822	0	423,828	58.00
60.00	LABORATORY	2,118	2,118	70,032	0	1,602,983	60.00
61.00	PBP CLINICAL LAB. SERVICE-PRGM. ONLY				0		61.00
65.00	RESPIRATORY THERAPY	0	0	233,924	0	329,367	65.00
66.00	PHYSICAL THERAPY	1,843	1,843	387,125	0	539,881	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	1,655	1,655	194,087	0	277,684	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	250,072	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	337,961	72.00
73.00	DRUGS CHARGED TO PATIENTS	106	106	0	0	310,066	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
75.01	SLEEP DISORDER	1,122	1,122	140,562	0	216,675	75.01
75.02	NEW HORIZON OP	831	831	23,070	0	37,683	75.02
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	0	0	0	0	0	90.00
91.00	EMERGENCY	4,584	4,584	1,653,223	0	1,883,124	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	65,873	65,873	7,200,787	-4,333,063	12,916,170	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	259	259	0	0	2,152	190.00
191.00	RESEARCH	0	0	0	0	0	191.00
192.00	PHYSICIANS' PRIVATE OFFICES	8,621	8,621	72,043	0	175,633	192.00
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	MARKETING/ PUBLIC RELATIONS	860	860	54,862	0	313,223	193.01
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per wkst. B, Part I)	614,157	13,881	2,327,504		4,333,063	202.00
203.00	Unit cost multiplier (wkst. B, Part I)	8.122373	0.183580	0.317631		0.323190	203.00
204.00	Cost to be allocated (per wkst. B, Part II)			0		103,540	204.00
205.00	Unit cost multiplier (wkst. B, Part II)			0.000000		0.007723	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151314

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

Worksheet B-1

Date/Time Prepared:
1/26/2012 10:06 am

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS)	
		7.00	8.00	9.00	10.00	11.00	
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
7.00	OPERATION OF PLANT	58,326					7.00
8.00	LAUNDRY & LINEN SERVICE	2,166	20,928				8.00
9.00	HOUSEKEEPING	314	716	1,896			9.00
10.00	DIETARY	6,270	771	0	1,847		10.00
11.00	CAFETERIA	0	0	3	0	195,681	11.00
13.00	NURSING ADMINISTRATION	219	0	0	0	2,372	13.00
14.00	CENTRAL SERVICES & SUPPLY	1,792	0	25	0	5,457	14.00
15.00	PHARMACY	0	0	0	0	4,240	15.00
16.00	MEDICAL RECORDS & LIBRARY	1,098	0	34	0	14,967	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	10,157	6,134	517	1,847	37,169	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	9,277	3,547	503	0	21,539	50.00
54.00	RADIOLOGY - DIAGNOSTIC	4,106	1,917	111	0	23,520	54.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	928	0	0	0	1,949	58.00
60.00	LABORATORY	2,118	0	77	0	2,997	60.00
61.00	PBP CLINICAL LAB. SERVICE-PRGM. ONLY						61.00
65.00	RESPIRATORY THERAPY	0	0	0	0	9,658	65.00
66.00	PHYSICAL THERAPY	1,843	1,469	58	0	13,319	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	1,655	381	74	0	8,507	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	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	106	0	32	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
75.01	SLEEP DISORDER	1,122	508	44	0	6,667	75.01
75.02	NEW HORIZON OP	831	0	0	0	1,044	75.02
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	CLINIC	0	0	0	0	0	90.00
91.00	EMERGENCY	4,584	5,435	343	0	36,407	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	48,586	20,878	1,821	1,847	189,812	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	259	0	16	0	0	190.00
191.00	RESEARCH	0	0	0	0	0	191.00
192.00	PHYSICIANS' PRIVATE OFFICES	8,621	50	59	0	3,770	192.00
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	MARKETING/ PUBLIC RELATIONS	860	0	0	0	2,099	193.01
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per wkst. B, Part I)	1,949,497	96,203	316,336	399,128	257,777	202.00
203.00	Unit cost multiplier (wkst. B, Part I)	33.424150	4.596856	166.843882	216.095290	1.317333	203.00
204.00	Cost to be allocated (per wkst. B, Part II)	51,422	20,040	5,337	59,430	1,510	204.00
205.00	Unit cost multiplier (wkst. B, Part II)	0.881631	0.957569	2.814873	32.176502	0.007717	205.00

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

Provider CCN: 151314

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

Worksheet A-8-1

Date/Time Prepared:
1/26/2012 10:06 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		4.00 EMPLOYEE BENEFITS	SVH - SELF-INSURANCE	1.00
2.00		1.00 CAP REL COSTS-BLDG & FIXT	SVH - CAPITAL	2.00
3.00		193.01 MARKETING/ PUBLIC RELATIONS	SVH - MARKETING	3.00
4.00		5.00 ADMINISTRATIVE & GENERAL	SVH - NON-CAPITAL	4.00
4.01		4.00 EMPLOYEE BENEFITS	DIRECT CHARGEBACKS - BENEFITS	4.01
4.02		5.00 ADMINISTRATIVE & GENERAL	DIRECT CHARGEBACKS - A&G	4.02
4.03		7.00 OPERATION OF PLANT	DIRECT CHARGEBACKS - PLANT OPS	4.03
4.04		54.00 RADIOLOGY - DIAGNOSTIC	DIRECT CHARGEBACKS - RADIOLOGY	4.04
4.05		91.00 EMERGENCY	DIRECT CHARGEBACKS - EMERGENCY	4.05
4.06		7.00 OPERATION OF PLANT	ASCENSION - TRIMEDX	4.06
4.07		4.00 EMPLOYEE BENEFITS	ASCENSION - PENSION	4.07
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		100.00	6.00
7.00		G		100.00	7.00
8.00		G		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:		HOME OFFICE		100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS
 Provider CCN: 151314
 Period: From 07/01/2010 To 06/30/2011
 Worksheet A-8-1
 Date/Time Prepared: 1/26/2012 10:06 am

	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	976,072	851,872	124,200	0	1.00	
2.00	190,463	0	190,463	9	2.00	
3.00	227,996	0	227,996	0	3.00	
4.00	1,362,773	0	1,362,773	0	4.00	
4.01	13,716	13,716	0	0	4.01	
4.02	160,391	160,391	0	0	4.02	
4.03	-13,876	-13,876	0	0	4.03	
4.04	3,077	3,077	0	0	4.04	
4.05	32,099	32,099	0	0	4.05	
4.06	316,830	340,531	-23,701	0	4.06	
4.07	360,996	360,996	0	0	4.07	
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to worksheet A-8, column 2, line 12.		3,630,537	1,748,806	1,881,731	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	ASCENSION HEALT	100.00	HOME OFFICE	6.00
7.00	ST VINCENT HEAL	100.00	HOME OFFICE	7.00
8.00	CATHOLIC HEALTH	100.00	HOME OFFICE	8.00
9.00		0.00		9.00
10.00		0.00		10.00
100.00	G. Other (financial or non-financial) specify:			100.00

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

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

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151314

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

Worksheet B-1

Date/Time Prepared:
1/26/2012 10:06 am

Cost Center Description		NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
		13.00	14.00	15.00	16.00	
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
7.00	OPERATION OF PLANT					7.00
8.00	LAUNDRY & LINEN SERVICE					8.00
9.00	HOUSEKEEPING					9.00
10.00	DIETARY					10.00
11.00	CAFETERIA					11.00
13.00	NURSING ADMINISTRATION	135				13.00
14.00	CENTRAL SERVICES & SUPPLY	0	25,921			14.00
15.00	PHARMACY	0	0	100		15.00
16.00	MEDICAL RECORDS & LIBRARY	0	0	0	1,387	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	24	0	0	167	30.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	20	0	0	263	50.00
54.00	RADIOLOGY - DIAGNOSTIC	19	0	0	314	54.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
60.00	LABORATORY	11	0	0	0	60.00
61.00	PBP CLINICAL LAB. SERVICE-PRGM. ONLY					61.00
65.00	RESPIRATORY THERAPY	11	0	0	0	65.00
66.00	PHYSICAL THERAPY	16	0	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	25,436	0	0	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	485	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	12	0	100	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
75.01	SLEEP DISORDER	0	0	0	0	75.01
75.02	NEW HORIZON OP	0	0	0	0	75.02
OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	CLINIC	0	0	0	0	90.00
91.00	EMERGENCY	22	0	0	328	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	135	25,921	100	1,072	118.00
NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	190.00
191.00	RESEARCH	0	0	0	0	191.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	315	192.00
193.00	NONPAID WORKERS	0	0	0	0	193.00
193.01	MARKETING/ PUBLIC RELATIONS	0	0	0	0	193.01
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per wkst. B, Part I)	91,476	257,618	411,152	537,562	202.00
203.00	Unit cost multiplier (wkst. B, Part I)	677.600000	9.938583	4,111.520000	387.571738	203.00
204.00	Cost to be allocated (per wkst. B, Part II)	2,503	17,664	2,400	13,075	204.00
205.00	Unit cost multiplier (wkst. B, Part II)	18.540741	0.681455	24.000000	9.426820	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151314

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

Worksheet C
Part I
Date/Time Prepared:
1/26/2012 10:06 am

Cost Center Description	Total Cost (from wkst: B, Part I, col. 26)	Therapy Limit Adj.	Title XVIII Hospital Cost			
			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	2,722,391		2,722,391	0	0	30.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	2,510,704		2,510,704	0	0	50.00
54.00 RADIOLOGY - DIAGNOSTIC	1,641,069		1,641,069	0	0	54.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	594,390		594,390	0	0	58.00
60.00 LABORATORY	2,216,092		2,216,092	0	0	60.00
61.00 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0		0	0	0	61.00
65.00 RESPIRATORY THERAPY	455,992	0	455,992	0	0	65.00
66.00 PHYSICAL THERAPY	820,784	0	820,784	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	448,050		448,050	0	0	69.00
70.00 ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	583,691		583,691	0	0	71.00
72.00 IMPLANTABLE DEVICES CHARGED TO PATIENTS	452,007		452,007	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	838,441		838,441	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
75.01 SLEEP DISORDER	342,663		342,663	0	0	75.01
75.02 NEW HORIZON OP	79,012		79,012	0	0	75.02
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0		0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00 CLINIC	0		0	0	0	90.00
91.00 EMERGENCY	2,917,145		2,917,145	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	610,488		610,488	0	0	92.00
200.00 Subtotal (see instructions)	17,232,919	0	17,232,919	0	0	200.00
201.00 Less Observation Beds	610,488		610,488	0	0	201.00
202.00 Total (see instructions)	16,622,431	0	16,622,431	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151314

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

Worksheet C
Part I
Date/Time Prepared:
1/26/2012 10:06 am

Cost Center Description	Title XVIII			Hospital	Cost	TEFRA Inpatient Ratio
	Charges			Cost or Other Ratio	10.00	
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	3,575,584		3,575,584			30.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	662,113	6,074,421	6,736,534	0.372700	0.000000	50.00
54.00 RADIOLOGY - DIAGNOSTIC	330,284	9,651,475	9,981,759	0.164407	0.000000	54.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	80,015	1,688,323	1,768,338	0.336129	0.000000	58.00
60.00 LABORATORY	701,528	6,772,196	7,473,724	0.296518	0.000000	60.00
61.00 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0	0	0.000000	0.000000	61.00
65.00 RESPIRATORY THERAPY	162,884	635,471	798,355	0.571164	0.000000	65.00
66.00 PHYSICAL THERAPY	448,180	2,107,759	2,555,939	0.321128	0.000000	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00 SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00 ELECTROCARDIOLOGY	101,489	1,664,681	1,766,170	0.253685	0.000000	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	1,090,064	1,388,837	2,478,901	0.235464	0.000000	71.00
72.00 IMPLANTABLE DEVICES CHARGED TO PATIENTS	648,490	84,077	732,567	0.617018	0.000000	72.00
73.00 DRUGS CHARGED TO PATIENTS	1,028,387	1,553,336	2,581,723	0.324760	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
75.01 SLEEP DISORDER	0	893,020	893,020	0.383713	0.000000	75.01
75.02 NEW HORIZON OP	0	0	0	0.000000	0.000000	75.02
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0			88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			89.00
90.00 CLINIC	0	0	0	0.000000	0.000000	90.00
91.00 EMERGENCY	13,887	4,408,416	4,422,303	0.659644	0.000000	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	21,808	396,405	418,213	1.459754	0.000000	92.00
200.00 Subtotal (see instructions)	8,864,713	37,318,417	46,183,130			200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	8,864,713	37,318,417	46,183,130			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151314

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

Worksheet C
Part I
Date/Time Prepared:
1/26/2012 10:06 am

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.000000			50.00
54.00	RADIOLOGY - DIAGNOSTIC	0.000000			54.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000			58.00
60.00	LABORATORY	0.000000			60.00
61.00	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0.000000			61.00
65.00	RESPIRATORY THERAPY	0.000000			65.00
66.00	PHYSICAL THERAPY	0.000000			66.00
67.00	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	SPEECH PATHOLOGY	0.000000			68.00
69.00	ELECTROCARDIOLOGY	0.000000			69.00
70.00	ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	IMPLANTABLE DEVICES 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
75.01	SLEEP DISORDER	0.000000			75.01
75.02	NEW HORIZON OP	0.000000			75.02
OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC				88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER				89.00
90.00	CLINIC	0.000000			90.00
91.00	EMERGENCY	0.000000			91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151314

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

Worksheet C
Part I
Date/Time Prepared:
1/26/2012 10:06 am

Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs
			Total Costs	RCE Disallowance	
			3.00	4.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 ADULTS & PEDIATRICS	2,722,391		2,722,391	0	0 30.00
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	2,510,704		2,510,704	0	0 50.00
54.00 RADIOLOGY - DIAGNOSTIC	1,641,069		1,641,069	0	0 54.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	594,390		594,390	0	0 58.00
60.00 LABORATORY	2,216,092		2,216,092	0	0 60.00
61.00 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0		0	0	0 61.00
65.00 RESPIRATORY THERAPY	455,992	0	455,992	0	0 65.00
66.00 PHYSICAL THERAPY	820,784	0	820,784	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	448,050		448,050	0	0 69.00
70.00 ELECTROENCEPHALOGRAPHY	0		0	0	0 70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	583,691		583,691	0	0 71.00
72.00 IMPLANTABLE DEVICES CHARGED TO PATIENTS	452,007		452,007	0	0 72.00
73.00 DRUGS CHARGED TO PATIENTS	838,441		838,441	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
75.01 SLEEP DISORDER	342,663		342,663	0	0 75.01
75.02 NEW HORIZON OP	79,012		79,012	0	0 75.02
OUTPATIENT SERVICE COST CENTERS					
88.00 RURAL HEALTH CLINIC	0		0	0	0 88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0 89.00
90.00 CLINIC	0		0	0	0 90.00
91.00 EMERGENCY	2,917,145		2,917,145	0	0 91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	614,030		614,030	0	0 92.00
200.00 Subtotal (see instructions)	17,236,461	0	17,236,461	0	0 200.00
201.00 Less Observation Beds	614,030		614,030	0	0 201.00
202.00 Total (see instructions)	16,622,431	0	16,622,431	0	0 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151314

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

Worksheet C
Part I
Date/Time Prepared:
1/26/2012 10:06 am

Cost Center Description	Title XIX			Hospital	Cost	TEFRA Inpatient Ratio	
	Charges			Cost or Other 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	3,575,584		3,575,584				30.00
ANCILLARY SERVICE COST CENTERS							
50.00 OPERATING ROOM	662,113	6,074,421	6,736,534	0.372700	0.000000		50.00
54.00 RADIOLOGY - DIAGNOSTIC	330,284	9,651,475	9,981,759	0.164407	0.000000		54.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	80,015	1,688,323	1,768,338	0.336129	0.000000		58.00
60.00 LABORATORY	701,528	6,772,196	7,473,724	0.296518	0.000000		60.00
61.00 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0	0	0.000000	0.000000		61.00
65.00 RESPIRATORY THERAPY	162,884	635,471	798,355	0.571164	0.000000		65.00
66.00 PHYSICAL THERAPY	448,180	2,107,759	2,555,939	0.321128	0.000000		66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000		67.00
68.00 SPEECH PATHOLOGY	0	0	0	0.000000	0.000000		68.00
69.00 ELECTROCARDIOLOGY	101,489	1,664,681	1,766,170	0.253685	0.000000		69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000		70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	1,090,064	1,388,837	2,478,901	0.235464	0.000000		71.00
72.00 IMPLANTABLE DEVICES CHARGED TO PATIENTS	648,490	84,077	732,567	0.617018	0.000000		72.00
73.00 DRUGS CHARGED TO PATIENTS	1,028,387	1,553,336	2,581,723	0.324760	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
75.01 SLEEP DISORDER	0	893,020	893,020	0.383713	0.000000		75.01
75.02 NEW HORIZON OP	0	0	0	0.000000	0.000000		75.02
OUTPATIENT SERVICE COST CENTERS							
88.00 RURAL HEALTH CLINIC	0	0	0	0.000000	0.000000		88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	0.000000		89.00
90.00 CLINIC	0	0	0	0.000000	0.000000		90.00
91.00 EMERGENCY	13,887	4,408,416	4,422,303	0.659644	0.000000		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	21,808	396,405	418,213	1.468223	0.000000		92.00
200.00 Subtotal (see instructions)	8,864,713	37,318,417	46,183,130				200.00
201.00 Less Observation Beds							201.00
202.00 Total (see instructions)	8,864,713	37,318,417	46,183,130				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 151314	Period: From 07/01/2010 To 06/30/2011	Worksheet C Part I Date/Time Prepared: 1/26/2012 10:06 am
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Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.000000			50.00
54.00	RADIOLOGY - DIAGNOSTIC	0.000000			54.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000			58.00
60.00	LABORATORY	0.000000			60.00
61.00	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0.000000			61.00
65.00	RESPIRATORY THERAPY	0.000000			65.00
66.00	PHYSICAL THERAPY	0.000000			66.00
67.00	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	SPEECH PATHOLOGY	0.000000			68.00
69.00	ELECTROCARDIOLOGY	0.000000			69.00
70.00	ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	IMPLANTABLE DEVICES 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
75.01	SLEEP DISORDER	0.000000			75.01
75.02	NEW HORIZON OP	0.000000			75.02
OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	0.000000			88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000			89.00
90.00	CLINIC	0.000000			90.00
91.00	EMERGENCY	0.000000			91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 151314	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part II Date/Time Prepared: 1/26/2012 10:06 am
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Cost Center Description	Title XVIII			Hospital	Cost	
	Capital Related Cost (from wkst. B, Part II, col. 26)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	104,481	6,736,534	0.015510	608,117	9,432	50.00
54.00 RADIOLOGY - DIAGNOSTIC	51,018	9,981,759	0.005111	152,078	777	54.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	11,814	1,768,338	0.006681	42,921	287	58.00
60.00 LABORATORY	32,283	7,473,724	0.004320	413,501	1,786	60.00
61.00 PBP CLINICAL LAB. SERVICE-PRGM. ONLY						61.00
65.00 RESPIRATORY THERAPY	2,823	798,355	0.003536	119,947	424	65.00
66.00 PHYSICAL THERAPY	23,073	2,555,939	0.009027	110,882	1,001	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00 ELECTROCARDIOLOGY	17,990	1,766,170	0.010186	95,872	977	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	19,264	2,478,901	0.007771	497,016	3,862	71.00
72.00 IMPLANTABLE DEVICES CHARGED TO PATIENTS	2,941	732,567	0.004015	277,395	1,114	72.00
73.00 DRUGS CHARGED TO PATIENTS	6,080	2,581,723	0.002355	605,066	1,425	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
75.01 SLEEP DISORDER	12,642	893,020	0.014156	0	0	75.01
75.02 NEW HORIZON OP	7,935	0	0.000000	0	0	75.02
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00 CLINIC	0	0	0.000000	0	0	90.00
91.00 EMERGENCY	66,605	4,422,303	0.015061	6,356	96	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	418,213	0.000000	5,157	0	92.00
200.00 Total (lines 50-199)	358,949	42,607,546		2,934,308	21,181	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151314

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

Worksheet D
Part IV
Date/Time Prepared:
1/26/2012 10:06 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
54.00 RADIOLOGY - DIAGNOSTIC	0	0	0	0	0	0	54.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	0	58.00
60.00 LABORATORY	0	0	0	0	0	0	60.00
61.00 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0	0	0	0	0	61.00
65.00 RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
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 IMPLANTABLE DEVICES 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
75.01 SLEEP DISORDER	0	0	0	0	0	0	75.01
75.02 NEW HORIZON OP	0	0	0	0	0	0	75.02
OUTPATIENT SERVICE COST CENTERS							
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	0	89.00
90.00 CLINIC	0	0	0	0	0	0	90.00
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: 151314

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

Worksheet D
Part IV
Date/Time Prepared:
1/26/2012 10:06 am

Cost Center Description		Title XVIII			Hospital		
		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	0	6,736,534	0.000000	0.000000	608,117	50.00
54.00	RADIOLOGY - DIAGNOSTIC	0	9,981,759	0.000000	0.000000	152,078	54.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	1,768,338	0.000000	0.000000	42,921	58.00
60.00	LABORATORY	0	7,473,724	0.000000	0.000000	413,501	60.00
61.00	PBP CLINICAL LAB. SERVICE-PRGM. ONLY						61.00
65.00	RESPIRATORY THERAPY	0	798,355	0.000000	0.000000	119,947	65.00
66.00	PHYSICAL THERAPY	0	2,555,939	0.000000	0.000000	110,882	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	ELECTROCARDIOLOGY	0	1,766,170	0.000000	0.000000	95,872	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,478,901	0.000000	0.000000	497,016	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	732,567	0.000000	0.000000	277,395	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	2,581,723	0.000000	0.000000	605,066	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
75.01	SLEEP DISORDER	0	893,020	0.000000	0.000000	0	75.01
75.02	NEW HORIZON OP	0	0	0.000000	0.000000	0	75.02
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	EMERGENCY	0	4,422,303	0.000000	0.000000	6,356	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	418,213	0.000000	0.000000	5,157	92.00
200.00	Total (lines 50-199)	0	42,607,546			2,934,308	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151314

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

Worksheet D
Part IV
Date/Time Prepared:
1/26/2012 10:06 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 Cost	
	11.00	12.00	13.00	21.00	22.00	
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	0	0	0	0	50.00
54.00 RADIOLOGY - DIAGNOSTIC	0	0	0	0	0	54.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00 LABORATORY	0	0	0	0	0	60.00
61.00 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0	0	0	0	61.00
65.00 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 IMPLANTABLE DEVICES 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
75.01 SLEEP DISORDER	0	0	0	0	0	75.01
75.02 NEW HORIZON OP	0	0	0	0	0	75.02
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 CLINIC	0	0	0	0	0	90.00
91.00 EMERGENCY	0	0	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00 Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151314

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

Worksheet D
Part IV
Date/Time Prepared:
1/26/2012 10:06 am

Cost Center Description		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
54.00	RADIOLOGY - DIAGNOSTIC	0	0		54.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	LABORATORY	0	0		60.00
61.00	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0		61.00
65.00	RESPIRATORY THERAPY	0	0		65.00
66.00	PHYSICAL THERAPY	0	0		66.00
67.00	OCCUPATIONAL THERAPY	0	0		67.00
68.00	SPEECH PATHOLOGY	0	0		68.00
69.00	ELECTROCARDIOLOGY	0	0		69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	IMPLANTABLE DEVICES 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
75.01	SLEEP DISORDER	0	0		75.01
75.02	NEW HORIZON OP	0	0		75.02
OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	0	0		88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	CLINIC	0	0		90.00
91.00	EMERGENCY	0	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00	Total (lines 50-199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151314	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part V Date/Time Prepared: 1/26/2012 10:06 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	0.372700	0	1,580,657	0	50.00
54.00	RADIOLOGY - DIAGNOSTIC	0.164407	0	2,655,177	0	54.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.336129	0	494,050	0	58.00
60.00	LABORATORY	0.296518	0	2,310,459	0	60.00
61.00	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0.000000	0	0	0	61.00
65.00	RESPIRATORY THERAPY	0.571164	0	42,779	0	65.00
66.00	PHYSICAL THERAPY	0.321128	0	585,060	0	66.00
67.00	OCCUPATIONAL THERAPY	0.000000	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0.000000	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0.253685	0	1,198,370	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.235464	0	503,263	0	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.617018	0	84,077	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.324760	0	1,028,950	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
75.01	SLEEP DISORDER	0.383713	0	0	0	75.01
75.02	NEW HORIZON OP	0.000000	0	0	0	75.02
OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0.000000				88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				89.00
90.00	CLINIC	0.000000	0	0	0	90.00
91.00	EMERGENCY	0.659644	0	978,119	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.459754	0	179,411	0	92.00
200.00	Subtotal (see instructions)		0	11,640,372	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	11,640,372	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151314	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part V Date/Time Prepared: 1/26/2012 10:06 am
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Cost Center Description	Costs			Hospital	Cost
	PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)		
	5.00	6.00	7.00		
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	0	589,111	0		50.00
54.00 RADIOLOGY - DIAGNOSTIC	0	436,530	0		54.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	166,065	0		58.00
60.00 LABORATORY	0	685,093	0		60.00
61.00 PBP CLINICAL LAB. SERVICE-PRGM. ONLY		0			61.00
65.00 RESPIRATORY THERAPY	0	24,434	0		65.00
66.00 PHYSICAL THERAPY	0	187,879	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	304,008	0		69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	118,500	0		71.00
72.00 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	51,877	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	0	334,162	0		73.00
74.00 RENAL DIALYSIS	0	0	0		74.00
75.00 ASC (NON-DISTINCT PART)	0	0	0		75.00
75.01 SLEEP DISORDER	0	0	0		75.01
75.02 NEW HORIZON OP	0	0	0		75.02
OUTPATIENT SERVICE COST CENTERS					
88.00 RURAL HEALTH CLINIC	0	0	0		88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00 CLINIC	0	0	0		90.00
91.00 EMERGENCY	0	645,210	0		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	261,896	0		92.00
200.00 Subtotal (see instructions)	0	3,804,765	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	3,804,765	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151314 Component CCN: 152314	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part V Date/Time Prepared: 1/26/2012 10:06 am
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Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Swing Beds - SNF	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)		
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0.372700	0	0	0		50.00
54.00 RADIOLOGY - DIAGNOSTIC	0.164407	0	0	0		54.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0.336129	0	0	0		58.00
60.00 LABORATORY	0.296518	0	0	0		60.00
61.00 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0.000000	0	0	0		61.00
65.00 RESPIRATORY THERAPY	0.571164	0	0	0		65.00
66.00 PHYSICAL THERAPY	0.321128	0	0	0		66.00
67.00 OCCUPATIONAL THERAPY	0.000000	0	0	0		67.00
68.00 SPEECH PATHOLOGY	0.000000	0	0	0		68.00
69.00 ELECTROCARDIOLOGY	0.253685	0	0	0		69.00
70.00 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0		70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.235464	0	0	0		71.00
72.00 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.617018	0	0	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	0.324760	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
75.01 SLEEP DISORDER	0.383713	0	0	0		75.01
75.02 NEW HORIZON OP	0.000000	0	0	0		75.02
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0.000000					88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0.000000					89.00
90.00 CLINIC	0.000000	0	0	0		90.00
91.00 EMERGENCY	0.659644	0	0	0		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	1.459754	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: 151314 Component CCN:15z314	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part V Date/Time Prepared: 1/26/2012 10:06 am
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Cost Center Description	Costs			Swing Beds - SNF	Cost
	PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)		
	5.00	6.00	7.00		
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	0	0	0		50.00
54.00 RADIOLOGY - DIAGNOSTIC	0	0	0		54.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
60.00 LABORATORY	0	0	0		60.00
61.00 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0	0		61.00
65.00 RESPIRATORY THERAPY	0	0	0		65.00
66.00 PHYSICAL THERAPY	0	0	0		66.00
67.00 OCCUPATIONAL THERAPY	0	0	0		67.00
68.00 SPEECH PATHOLOGY	0	0	0		68.00
69.00 ELECTROCARDIOLOGY	0	0	0		69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00 IMPLANTABLE DEVICES 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
75.01 SLEEP DISORDER	0	0	0		75.01
75.02 NEW HORIZON OP	0	0	0		75.02
OUTPATIENT SERVICE COST CENTERS					
88.00 RURAL HEALTH CLINIC	0	0	0		88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00 CLINIC	0	0	0		90.00
91.00 EMERGENCY	0	0	0		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00 Subtotal (see instructions)	0	0	0		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00 Net Charges (line 200 +/- line 201)	0	0	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 151314		Period: From 07/01/2010 To 06/30/2011		Worksheet D Part I Date/Time Prepared: 1/26/2012 10:06 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	172,536	33,241	139,295	1,915	72.74	30.00
200.00	Total (lines 30-199)	172,536		139,295	1,915		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 151314		Period: From 07/01/2010 To 06/30/2011		Worksheet D Part I Date/Time Prepared: 1/26/2012 10:06 am	
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	Title XIX Hospital		Cost	
		6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	61	4,437			30.00	
200.00	Total (lines 30-199)	61	4,437			200.00	

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 151314	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part II Date/Time Prepared: 1/26/2012 10:06 am
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Cost Center Description	Title XIX			Hospital	Cost		
	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
	1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	104,481	6,736,534	0.015510	51,081	792	50.00
54.00	RADIOLOGY - DIAGNOSTIC	51,018	9,981,759	0.005111	52,098	266	54.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	11,814	1,768,338	0.006681	0	0	58.00
60.00	LABORATORY	32,283	7,473,724	0.004320	55,232	239	60.00
61.00	PBP CLINICAL LAB. SERVICE-PRGM. ONLY						61.00
65.00	RESPIRATORY THERAPY	2,823	798,355	0.003536	27,481	97	65.00
66.00	PHYSICAL THERAPY	23,073	2,555,939	0.009027	1,420	13	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	ELECTROCARDIOLOGY	17,990	1,766,170	0.010186	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	19,264	2,478,901	0.007771	13,037	101	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	2,941	732,567	0.004015	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	6,080	2,581,723	0.002355	75,177	177	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
75.01	SLEEP DISORDER	12,642	893,020	0.014156	0	0	75.01
75.02	NEW HORIZON OP	7,935	0	0.000000	0	0	75.02
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	CLINIC	0	0	0.000000	0	0	90.00
91.00	EMERGENCY	66,605	4,422,303	0.015061	6,301	95	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	418,213	0.000000	0	0	92.00
200.00	Total (lines 50-199)	358,949	42,607,546		281,827	1,780	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 151314		Period: From 07/01/2010 To 06/30/2011		Worksheet D Part III Date/Time Prepared: 1/26/2012 10:06 am	
Cost Center Description	Title XIX			Hospital		Total Costs (sum of cols. 1 through 3, minus col. 4)	
	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Cost		
	1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
200.00	Total (lines 30-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 151314		Period: From 07/01/2010 To 06/30/2011		Worksheet D Part III Date/Time Prepared: 1/26/2012 10:06 am	
Cost Center Description		Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. Nursing School	Cost
		6.00	7.00	8.00	9.00	11.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	1,915	0.00	61	0	0	30.00
200.00	Total (lines 30-199)	1,915		61	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 151314		Period: From 07/01/2010 To 06/30/2011		Worksheet D Part III Date/Time Prepared: 1/26/2012 10:06 am	
Cost Center Description		PSA Adj. Allied Health Cost	PSA Adj. All Other Medical Education Cost	Title XIX		Hospital	
		12.00	13.00			Cost	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	0	0			30.00	
200.00	Total (Lines 30-199)	0	0			200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151314

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

Worksheet D
Part IV
Date/Time Prepared:
1/26/2012 10:06 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	0	50.00
54.00 RADIOLOGY - DIAGNOSTIC	0	0	0	0	0	0	54.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	0	58.00
60.00 LABORATORY	0	0	0	0	0	0	60.00
61.00 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0	0	0	0	0	61.00
65.00 RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
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 IMPLANTABLE DEVICES 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
75.01 SLEEP DISORDER	0	0	0	0	0	0	75.01
75.02 NEW HORIZON OP	0	0	0	0	0	0	75.02
OUTPATIENT SERVICE COST CENTERS							
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	0	89.00
90.00 CLINIC	0	0	0	0	0	0	90.00
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: 151314

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

Worksheet D
Part IV
Date/Time Prepared:
1/26/2012 10:06 am

Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Title XIX		Hospital		Inpatient Program Charges	
		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)	Cost		
	6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS							
50.00 OPERATING ROOM	0	6,736,534	0.000000	0.000000	51,081	50.00	
54.00 RADIOLOGY - DIAGNOSTIC	0	9,981,759	0.000000	0.000000	52,098	54.00	
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	1,768,338	0.000000	0.000000	0	58.00	
60.00 LABORATORY	0	7,473,724	0.000000	0.000000	55,232	60.00	
61.00 PBP CLINICAL LAB. SERVICE-PRGM. ONLY						61.00	
65.00 RESPIRATORY THERAPY	0	798,355	0.000000	0.000000	27,481	65.00	
66.00 PHYSICAL THERAPY	0	2,555,939	0.000000	0.000000	1,420	66.00	
67.00 OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00	
68.00 SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00	
69.00 ELECTROCARDIOLOGY	0	1,766,170	0.000000	0.000000	0	69.00	
70.00 ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00	
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,478,901	0.000000	0.000000	13,037	71.00	
72.00 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	732,567	0.000000	0.000000	0	72.00	
73.00 DRUGS CHARGED TO PATIENTS	0	2,581,723	0.000000	0.000000	75,177	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	
75.01 SLEEP DISORDER	0	893,020	0.000000	0.000000	0	75.01	
75.02 NEW HORIZON OP	0	0	0.000000	0.000000	0	75.02	
OUTPATIENT SERVICE COST CENTERS							
88.00 RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00	
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00	
90.00 CLINIC	0	0	0.000000	0.000000	0	90.00	
91.00 EMERGENCY	0	4,422,303	0.000000	0.000000	6,301	91.00	
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	418,213	0.000000	0.000000	0	92.00	
200.00 Total (lines 50-199)	0	42,607,546			281,827	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151314

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

Worksheet D
Part IV
Date/Time Prepared:
1/26/2012 10:06 am

Cost Center Description	Title XIX			Hospital	Cost	
	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
	11.00	12.00	13.00	21.00	22.00	
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	0	0	0	0	50.00
54.00 RADIOLOGY - DIAGNOSTIC	0	0	0	0	0	54.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00 LABORATORY	0	0	0	0	0	60.00
61.00 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0	0	0	0	61.00
65.00 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 IMPLANTABLE DEVICES 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
75.01 SLEEP DISORDER	0	0	0	0	0	75.01
75.02 NEW HORIZON OP	0	0	0	0	0	75.02
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 CLINIC	0	0	0	0	0	90.00
91.00 EMERGENCY	0	0	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00 Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151314	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part IV Date/Time Prepared: 1/26/2012 10:06 am
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Cost Center Description	Title XIX		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
54.00 RADIOLOGY - DIAGNOSTIC	0	0		54.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00 LABORATORY	0	0		60.00
61.00 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0		61.00
65.00 RESPIRATORY THERAPY	0	0		65.00
66.00 PHYSICAL THERAPY	0	0		66.00
67.00 OCCUPATIONAL THERAPY	0	0		67.00
68.00 SPEECH PATHOLOGY	0	0		68.00
69.00 ELECTROCARDIOLOGY	0	0		69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00 IMPLANTABLE DEVICES 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
75.01 SLEEP DISORDER	0	0		75.01
75.02 NEW HORIZON OP	0	0		75.02
OUTPATIENT SERVICE COST CENTERS				
88.00 RURAL HEALTH CLINIC	0	0		88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00 CLINIC	0	0		90.00
91.00 EMERGENCY	0	0		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00 Total (lines 50-199)	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 151314	Period: From 07/01/2010 To 06/30/2011	Worksheet D-1 Date/Time Prepared: 1/26/2012 10:06 am
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Title XVIII		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)		2,475 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,915 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)		1,915 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		261 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)		196 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0 7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		103 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		933 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)		261 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)		196 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)		2,722,391 21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0 22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0 23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0 24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		15,711 25.00
26.00	Total swing-bed cost (see instructions)		537,194 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,185,197 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28.00	General inpatient routine service charges (excluding swing-bed charges)		4,024,731 28.00
29.00	Private room charges (excluding swing-bed charges)		0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)		4,024,731 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.542942 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)		2,101.69 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)		2,185,197 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)		1,141.10 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,064,646 39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0 40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,064,646 41.00

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COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151314	Period: From 07/01/2010 To 06/30/2011	Worksheet D-1 Date/Time Prepared: 1/26/2012 10:06 am
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Cost Center Description	Title XVIII			Hospital	Cost
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00 NURSERY (title V & XIX only)					42.00
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT					43.00
44.00 CORONARY CARE UNIT					44.00
45.00 BURN INTENSIVE CARE UNIT					45.00
46.00 SURGICAL INTENSIVE CARE UNIT					46.00
47.00 OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description					
					1.00
48.00 Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					1,013,531
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,078,177
PASS THROUGH COST ADJUSTMENTS					
50.00 Pass through costs applicable to Program inpatient routine services (from wkst. D, sum of Parts I and III)					0
51.00 Pass through costs applicable to Program inpatient ancillary services (from wkst. D, sum of Parts II and IV)					0
52.00 Total Program excludable cost (sum of lines 50 and 51)					0
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00 Program discharges					0
55.00 Target amount per discharge					0.00
56.00 Target amount (line 54 x line 55)					0
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00 Bonus payment (see instructions)					0
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0
62.00 Relief payment (see instructions)					0
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0
PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					297,827
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					223,656
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					521,483
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY					
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)					70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00 Program routine service cost (line 9 x line 71)					72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from worksheet B, Part II, column 26, line 45)					75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00 Program capital-related costs (line 9 x line 76)					77.00
78.00 Inpatient routine service cost (line 74 minus line 77)					78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00 Inpatient routine service cost per diem limitation					81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00 Reasonable inpatient routine service costs (see instructions)					83.00
84.00 Program inpatient ancillary services (see instructions)					84.00
85.00 Utilization review - physician compensation (see instructions)					85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00 Total observation bed days (see instructions)					535
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,141.10
89.00 Observation bed cost (line 87 x line 88) (see instructions)					610,488

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COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151314	Period: From 07/01/2010 To 06/30/2011	Worksheet D-1 Date/Time Prepared: 1/26/2012 10:06 am
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Cost Center Description	Cost	Title XVIII		Hospital	Cost	
		Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	0	0	0.000000	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	91.00
92.00	Allied health cost	0	0	0.000000	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 151314	Period: From 07/01/2010 To 06/30/2011	Worksheet D-1 Date/Time Prepared: 1/26/2012 10:06 am
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Cost Center Description		Title XIX	Hospital	Cost
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,475	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,915	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)		1,915	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		457	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		103	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		61	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING-BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		2,722,391	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		524,508	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,197,883	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		4,024,731	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		4,024,731	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.546094	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)		2,101.69	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)		2,197,883	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)		1,147.72	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		70,011	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)		70,011	41.00

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COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 151314	Period: From 07/01/2010 To 06/30/2011	Worksheet D-1 Date/Time Prepared: 1/26/2012 10:06 am
Title XIX			Hospital		Cost
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)				42.00
Intensive Care Type Inpatient Hospital Units					
43.00	INTENSIVE CARE UNIT				43.00
44.00	CORONARY CARE UNIT				44.00
45.00	BURN INTENSIVE CARE UNIT				45.00
46.00	SURGICAL INTENSIVE CARE UNIT				46.00
47.00	OTHER SPECIAL CARE (SPECIFY)				47.00
Cost Center Description					1.00
48.00	Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)				91,772 48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				161,783 49.00
PASS THROUGH COST ADJUSTMENTS					
50.00	Pass through costs applicable to Program inpatient routine services (from wkst. D, sum of Parts I and III)				0 50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from wkst. D, sum of Parts II and IV)				0 51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)				0 52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				0 53.00
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00	Program discharges				0 54.00
55.00	Target amount per discharge				0.00 55.00
56.00	Target amount (line 54 x line 55)				0 56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)				0 57.00
58.00	Bonus payment (see instructions)				0 58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket				0.00 59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket				0.00 60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)				0 61.00
62.00	Relief payment (see instructions)				0 62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)				0 63.00
PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)				0 64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)				0 65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)				0 66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)				0 67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)				0 68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)				0 69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY					
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)				70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)				71.00
72.00	Program routine service cost (line 9 x line 71)				72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)				73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)				74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from worksheet B, Part II, column 26, line 45)				75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)				76.00
77.00	Program capital-related costs (line 9 x line 76)				77.00
78.00	Inpatient routine service cost (line 74 minus line 77)				78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)				79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)				80.00
81.00	Inpatient routine service cost per diem limitation				81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)				82.00
83.00	Reasonable inpatient routine service costs (see instructions)				83.00
84.00	Program inpatient ancillary services (see instructions)				84.00
85.00	Utilization review - physician compensation (see instructions)				85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)				86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00	Total observation bed days (see instructions)				535 87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				1,147.72 88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				614,030 89.00

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COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 151314	Period: From 07/01/2010 To 06/30/2011	Worksheet D-1 Date/Time Prepared: 1/26/2012 10:06 am
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Cost Center Description	Cost	Title XIX		Hospital	Cost		
		Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 151314	Period: From 07/01/2010 To 06/30/2011	Worksheet D-3 Date/Time Prepared: 1/26/2012 10:06 am
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Cost Center Description	Title XVIII		Hospital		Cost
	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)		
	1.00	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 ADULTS & PEDIATRICS		745,289			30.00
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	0.372700	608,117	226,645		50.00
54.00 RADIOLOGY - DIAGNOSTIC	0.164407	152,078	25,003		54.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0.336129	42,921	14,427		58.00
60.00 LABORATORY	0.296518	413,501	122,610		60.00
61.00 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0.000000	0	0		61.00
65.00 RESPIRATORY THERAPY	0.571164	119,947	68,509		65.00
66.00 PHYSICAL THERAPY	0.321128	110,882	35,607		66.00
67.00 OCCUPATIONAL THERAPY	0.000000	0	0		67.00
68.00 SPEECH PATHOLOGY	0.000000	0	0		68.00
69.00 ELECTROCARDIOLOGY	0.253685	95,872	24,321		69.00
70.00 ELECTROENCEPHALOGRAPHY	0.000000	0	0		70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.235464	497,016	117,029		71.00
72.00 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.617018	277,395	171,158		72.00
73.00 DRUGS CHARGED TO PATIENTS	0.324760	605,066	196,501		73.00
74.00 RENAL DIALYSIS	0.000000	0	0		74.00
75.00 ASC (NON-DISTINCT PART)	0.000000	0	0		75.00
75.01 SLEEP DISORDER	0.383713	0	0		75.01
75.02 NEW HORIZON OP	0.000000	0	0		75.02
OUTPATIENT SERVICE COST CENTERS					
88.00 RURAL HEALTH CLINIC	0.000000		0		88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0		89.00
90.00 CLINIC	0.000000	0	0		90.00
91.00 EMERGENCY	0.659644	6,356	4,193		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	1.459754	5,157	7,528		92.00
200.00 Total (sum of lines 50-94 and 96-98)		2,934,308	1,013,531		200.00
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0		201.00
202.00 Net Charges (line 200 minus line 201)		2,934,308			202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 151314 Component CCN: 152314	Period: From 07/01/2010 To 06/30/2011	Worksheet D-3 Date/Time Prepared: 1/26/2012 10:06 am
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Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	Cost
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS		299,520		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.372700	2,915	1,086	50.00
54.00	RADIOLOGY - DIAGNOSTIC	0.164407	9,046	1,487	54.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.336129	0	0	58.00
60.00	LABORATORY	0.296518	45,632	13,531	60.00
61.00	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0.000000	0	0	61.00
65.00	RESPIRATORY THERAPY	0.571164	15,456	8,828	65.00
66.00	PHYSICAL THERAPY	0.321128	245,235	78,752	66.00
67.00	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	ELECTROCARDIOLOGY	0.253685	5,617	1,425	69.00
70.00	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.235464	39,362	9,268	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.617018	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.324760	110,843	35,997	73.00
74.00	RENAL DIALYSIS	0.000000	0	0	74.00
75.00	ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
75.01	SLEEP DISORDER	0.383713	0	0	75.01
75.02	NEW HORIZON OP	0.000000	0	0	75.02
OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	CLINIC	0.000000	0	0	90.00
91.00	EMERGENCY	0.659644	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.459754	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		474,106	150,374	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)		474,106		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 151314	Period: From 07/01/2010 To 06/30/2011	Worksheet D-3 Date/Time Prepared: 1/26/2012 10:06 am
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Cost Center Description	Title XIX		Hospital		Cost
	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)		
	1.00	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 ADULTS & PEDIATRICS		141,488			30.00
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	0.372700	51,081	19,038		50.00
54.00 RADIOLOGY - DIAGNOSTIC	0.164407	52,098	8,565		54.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0.336129	0	0		58.00
60.00 LABORATORY	0.296518	55,232	16,377		60.00
61.00 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0.000000	0	0		61.00
65.00 RESPIRATORY THERAPY	0.571164	27,481	15,696		65.00
66.00 PHYSICAL THERAPY	0.321128	1,420	456		66.00
67.00 OCCUPATIONAL THERAPY	0.000000	0	0		67.00
68.00 SPEECH PATHOLOGY	0.000000	0	0		68.00
69.00 ELECTROCARDIOLOGY	0.253685	0	0		69.00
70.00 ELECTROENCEPHALOGRAPHY	0.000000	0	0		70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.235464	13,037	3,070		71.00
72.00 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.617018	0	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	0.324760	75,177	24,414		73.00
74.00 RENAL DIALYSIS	0.000000	0	0		74.00
75.00 ASC (NON-DISTINCT PART)	0.000000	0	0		75.00
75.01 SLEEP DISORDER	0.383713	0	0		75.01
75.02 NEW HORIZON OP	0.000000	0	0		75.02
OUTPATIENT SERVICE COST CENTERS					
88.00 RURAL HEALTH CLINIC	0.000000	0	0		88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0		89.00
90.00 CLINIC	0.000000	0	0		90.00
91.00 EMERGENCY	0.659644	6,301	4,156		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	1.468223	0	0		92.00
200.00 Total (sum of lines 50-94 and 96-98)		281,827	91,772		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)		281,827			202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151314	Period: From 07/01/2010 To 06/30/2011	Worksheet E Part B Date/Time Prepared: 1/26/2012 10:06 am
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES-				
1.00	Medical and other services (see instructions)			3,804,765 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			0 2.00
3.00	PPS payments			0 3.00
4.00	Outlier payment (see instructions)			0 4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000 5.00
6.00	Line 2 times line 5			0 6.00
7.00	Sum of line 3 plus line 4 divided by line 6			0.00 7.00
8.00	Transitional corridor payment (see instructions)			0 8.00
9.00	Ancillary service other pass through costs from worksheet D, Part IV, column 13, line 200			0 9.00
10.00	Organ acquisitions			0 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			3,804,765 11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges			0 12.00
13.00	Organ acquisition charges (from worksheet D-4, Part III, line 69, col. 4)			0 13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0 14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR 413.13(e)			0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000 17.00
18.00	Total customary charges (see instructions)			0 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0 19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0 20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)			3,842,813 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)			29,596 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			1,858,772 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)			1,954,445 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)			1,954,445 30.00
31.00	Primary payer payments			1,077 31.00
32.00	Subtotal (line 30 minus line 31)			1,953,368 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)			680,604 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			680,604 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			628,080 36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)			2,633,972 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)			2,633,972 40.00
41.00	Interim payments			2,702,470 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)			-68,498 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: 151314	Period: From 07/01/2010 To 06/30/2011	Worksheet E Part B Date/Time Prepared: 1/26/2012 10:06 am
		Title XVIII	Hospital
			Cost
			Overrides
			1.00
WORKSHEET OVERRIDE VALUES			
112.00	override of Ancillary service charges (line 12)		0 112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 151314		Period: From 07/01/2010 To 06/30/2011		Worksheet E-1 Part I Date/Time Prepared: 1/26/2012 10:06 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		1,623,962		2,283,557	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER	05/19/2011	116,342	05/19/2011	63,128	3.01	
3.02		02/03/2011	435,479	02/03/2011	355,785	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		551,821		418,913	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to wkst. E or wkst. E-3, line and column as appropriate)		2,175,783		2,702,470	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00	
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00	
6.01	SETTLEMENT TO PROVIDER		0		0	6.01	
6.02	SETTLEMENT TO PROGRAM		246,978		68,498	6.02	
7.00	Total Medicare program liability (see instructions)		1,928,805		2,633,972	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: 151314 Component CCN: 152314		Period: From 07/01/2010 To 06/30/2011		Worksheet E-1 Part I Date/Time Prepared: 1/26/2012 10:06 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		591,264		0		1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0		2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER	05/19/2011	20,511		0		3.01
3.02		02/03/2001	115,434		0		3.02
3.03			0		0		3.03
3.04			0		0		3.04
3.05			0		0		3.05
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0		3.50
3.51			0		0		3.51
3.52			0		0		3.52
3.53			0		0		3.53
3.54			0		0		3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		135,945		0		3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to wkst. E or wkst. E-3, line and column as appropriate)		727,209		0		4.00
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						5.00
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0		5.01
5.02			0		0		5.02
5.03			0		0		5.03
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0		5.50
5.51			0		0		5.51
5.52			0		0		5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0		5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)						6.00
6.01	SETTLEMENT TO PROVIDER		0		0		6.01
6.02	SETTLEMENT TO PROGRAM		57,194		0		6.02
7.00	Total Medicare program liability (see instructions)		670,015		0		7.00
				Contractor Number	Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor						8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 151314	Period: From 07/01/2010	Worksheet E-2
		Component CCN: 152314	To 06/30/2011	Date/Time Prepared: 1/26/2012 10:06 am
		Title XVIII	Swing Beds - SNF	Cost
			Part A	Part B
			1.00	2.00
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)		526,698	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)		151,878	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		457	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)		678,576	0 8.00
9.00	Primary payer payments (see instructions)		0	0 9.00
10.00	Subtotal (line 8 minus line 9)		678,576	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)		678,576	0 12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		8,561	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)		670,015	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)		670,015	0 19.00
20.00	Interim payments		727,209	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)		-57,194	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: 151314	Period: From 07/01/2010 To 06/30/2011	Worksheet E-3 Part V Date/Time Prepared: 1/26/2012 10:06 am
		Title XVIII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHS)				
1.00	Inpatient services			2,078,177 1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction)			0 2.00
3.00	Organ acquisition			0 3.00
4.00	Subtotal (sum of lines 1 thru 3)			2,078,177 4.00
5.00	Primary payer payments			0 5.00
6.00	Total cost (line 5 less line 6) . For CAH (see instructions)			2,098,959 6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
7.00	Routine service charges			0 7.00
8.00	Ancillary service charges			0 8.00
9.00	Organ acquisition charges, net of revenue			0 9.00
10.00	Total reasonable charges			0 10.00
Customary charges				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0 12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.000000 13.00
14.00	Total customary charges (see instructions)			0 14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)			0 15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)			0 16.00
17.00	Cost of teaching physicians (from worksheet D-5, Part II, column 3, line 20) (see instructions)			0 17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from worksheet E-4, line 49)			0 18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)			2,098,959 19.00
20.00	Deductibles (exclude professional component)			233,771 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)			1,865,188 22.00
23.00	Coinsurance			566 23.00
24.00	Subtotal (line 22 minus line 23)			1,864,622 24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			64,183 25.00
26.00	Adjusted reimbursable bad debts (see instructions)			64,183 26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			55,686 27.00
28.00	Subtotal (sum of lines 24 and 25 or 26(line 26 hospital and subprovider only))			1,928,805 28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 29.00
29.99	Recovery of Accelerated Depreciation			0 29.99
30.00	Subtotal (line 28, plus or minus lines 29)			1,928,805 30.00
31.00	Interim payments			2,175,783 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)			-246,978 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: 151314	Period: From 07/01/2010 To 06/30/2011	Worksheet E-3 Part VII Date/Time Prepared: 1/26/2012 10:06 am
		Title XIX	Hospital	Cost
				1.00
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services			161,783 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)			161,783 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)			161,783 7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges			141,488 8.00
9.00	Ancillary service charges			281,827 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)			423,315 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)			423,315 16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 7) (see instructions)			261,532 17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 7 exceeds line 16) (see instructions)			0 18.00
19.00	Interns and Residents (see instructions)			0 19.00
20.00	Cost of Teaching Physicians (see instructions)			0 20.00
21.00	Cost of covered services (line 7)			161,783 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)			161,783 29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)			0 30.00
31.00	Subtotal (sum of lines 19 and 20, plus line 29 minus line 30)			161,783 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)			161,783 36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 37.00
38.00	Subtotal (line 36 ± line 37)			161,783 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)			161,783 40.00
41.00	Interim payments			161,772 41.00
42.00	Balance due provider/program (line 40 minus 41)			11 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: 151314

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

Worksheet G

Date/Time Prepared:
1/26/2012 10:06 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	3,696,907	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	8,308,324	0	0	0	4.00
5.00	Other receivable	167,838	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-6,204,696	0	0	0	6.00
7.00	Inventory	288,709	0	0	0	7.00
8.00	Prepaid expenses	578,851	0	0	0	8.00
9.00	Other current assets	175,028	0	0	0	9.00
10.00	Due from other funds	31,008	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	7,041,969	0	0	0	11.00
FIXED ASSETS						
12.00	Land	0	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	88,109	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	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	248,189	0	0	0	23.00
24.00	Accumulated depreciation	-62,772	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)	273,526	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	4,211,088	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	4,211,088	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	11,526,583	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	793,871	0	0	0	37.00
38.00	Salaries, wages, and fees payable	888,525	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	353,309	0	0	0	43.00
44.00	Other current liabilities	524,869	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2,560,574	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	1,167,479	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	1,167,479	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	3,728,053	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	7,798,530				52.00
53.00	Specific purpose fund		0			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)	7,798,530	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	11,526,583	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151314

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

Worksheet G-1

Date/Time Prepared:
1/26/2012 10:06 am

	General Fund		Special Purpose Fund		
	1.00	2.00	3.00	4.00	
1.00 Fund balances at beginning of period		6,304,222		0	1.00
2.00 Net income (loss) (from Wkst. G-3, line 29)		1,467,277			2.00
3.00 Total (sum of line 1 and line 2)		7,771,499		0	3.00
4.00 CONTRIBUTIONS	19,833		0		4.00
5.00 GRANT REVENUE	9,433		0		5.00
6.00 ROUNDING	2		0		6.00
7.00	0		0		7.00
8.00	0		0		8.00
9.00	0		0		9.00
10.00 Total additions (sum of line 4-9)		29,268		0	10.00
11.00 Subtotal (line 3 plus line 10)		7,800,767		0	11.00
12.00 NET ASSETS RELEASED FROM RESTRICTION	2,237		0		12.00
13.00	0		0		13.00
14.00	0		0		14.00
15.00	0		0		15.00
16.00	0		0		16.00
17.00	0		0		17.00
18.00 Total deductions (sum of lines 12-17)		2,237		0	18.00
19.00 Fund balance at end of period per balance sheet (line 11 minus line 18)		7,798,530		0	19.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151314

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

Worksheet G-1

Date/Time Prepared:
1/26/2012 10:06 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	0					4.00
5.00	0					5.00
6.00	0					6.00
7.00	0					7.00
8.00	0					8.00
9.00	0					9.00
10.00						10.00
11.00						11.00
12.00	0					12.00
13.00	0					13.00
14.00	0					14.00
15.00	0					15.00
16.00	0					16.00
17.00	0					17.00
18.00						18.00
19.00						19.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 151314	Period: From 07/01/2010 To 06/30/2011	Worksheet G-3 Date/Time Prepared: 1/26/2012 10:06 am
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		1.00	
1.00	Total patient revenues (from wkst. G-2, Part I, column 3, line 28)	47,787,703	1.00
2.00	Less contractual allowances and discounts on patients' accounts	25,403,721	2.00
3.00	Net patient revenues (line 1 minus line 2)	22,383,982	3.00
4.00	Less total operating expenses (from wkst. G-2, Part II, line 43)	16,794,355	4.00
5.00	Net income from service to patients (line 3 minus line 4)	5,589,627	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	62,012	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	20,131	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	165,598	22.00
23.00	Governmental appropriations	0	23.00
24.00	GRANTS	34,736	24.00
24.01	MISC REVENUE	3,065	24.01
24.02	NET ASSETS RELEASED FROM RESTRICTION	2,237	24.02
24.03	NONOPERATING GAINS/LOSSES	29,014	24.03
25.00	Total other income (sum of lines 6-24)	316,793	25.00
26.00	Total (line 5 plus line 25)	5,906,420	26.00
27.00	BAD DEBT	4,439,143	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	4,439,143	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,467,277	29.00