

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 150175	Period: From 10/01/2010 To 09/30/2011	Worksheet S Parts I-III Date/Time Prepared: 2/28/2012 3:05 pm
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PART I - COST REPORT STATUS

Provider use only	1. <input type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 2/28/2012 Time: 3:05 pm
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by HEART HOSPITAL AT DEACONESS GATEWAY for the cost reporting period beginning 10/01/2010 and ending 09/30/2011 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.

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

Title

Date

Cost Center Description	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	31,680	53,649	1,409,795	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
4.00 SUBPROVIDER I	0	0	0		0	4.00
5.00 Swing bed - SNF	0	0	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	31,680	53,649	1,409,795	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150175		Period: From 10/01/2010 To 09/30/2011		Worksheet S-2 Part I Date/Time Prepared: 2/28/2012 3:03 pm				
1.00 Hospital and Hospital Health Care Complex Address:		2.00 PO Box:		3.00 Zip Code: 47630-		4.00 County: WARRICK				
1.00	Street: 4007 GATEWAY BOULEVARD	State: IN		Zip Code: 47630-		County: WARRICK			1.00	
2.00	City: NEWBURGH	State: IN		Zip Code: 47630-		County: WARRICK			2.00	
Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00		
V		XVIII	XIX							
3.00	Hospital and Hospital-Based Component Identification: Hospital	HEART HOSPITAL AT DEACONESS GATEWAY	150175	21780	1	02/23/2009	N	P	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF						N	N	N	7.00
8.00	Swing Beds - NF						N	N	N	8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) 1									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00
						From:	To:			
						1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)					10/01/2010	09/30/2011		20.00	
21.00	Type of Control (see instructions)					4			21.00	
Inpatient PPS Information										
22.00	Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	N		22.00	
23.00	Indicate in column 1 the method used to capture Medicaid (title XIX) days reported on lines 24 and/or 25 of this worksheet during the cost reporting period by entering a "1" if days are based on the date of admission, "2" if days are based on census days (also referred to as the day count), or "3" if the days are based on the date of discharge. Is the method of identifying the days in the current cost reporting period different from the method used in the prior cost reporting period? Enter in column 2 "Y" for yes or "N" for no.					3	N		23.00	
		In-State Medicaid paid days	In-State Medicaid eligible days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible days	Medicaid HMO days	Other Medicaid days			
		1.00	2.00	3.00	4.00	5.00	6.00			
24.00	If line 22 and/or line 45 is "yes", and this provider is an IPPS hospital enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible days in col. 4, Medicaid HMO days in col. 5, and other Medicaid days in col. 6.	0	0	0	0	0	0		24.00	
25.00	If this provider is an IRF, enter the in-State Medicaid paid days in column 1, the in State Medicaid eligible days in column 2, the out of State Medicaid paid days in column 3, the out of State Medicaid eligible days in column 4, Medicaid HMO days in column 5, and other Medicaid days in column 6. For all columns include in these days the labor and delivery days.	0	0	0	0	0	0		25.00	
							1.00			
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter (1) for urban or (2) for rural.							1	26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period? Enter (1) for urban or (2) for rural.							1	27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.							0	35.00	
						Beginning:	Ending:			
						1.00	2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.								36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.							0	37.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150175	Period: From 10/01/2010 To 09/30/2011	Worksheet S-2 Part I Date/Time Prepared: 2/28/2012 3:03 pm		
		Beginning:	Ending:			
		1.00	2.00			
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.				38.00	
		V	XVIII	XIX		
		1.00	2.00	3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00	
46.00	Is this facility eligible for the special exceptions payment pursuant to 42 CFR Section §412.348(g)? If yes, complete Worksheet L, Part III and L-1, Parts I through III	N	N	N	46.00	
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N	47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00	
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.				57.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.				58.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59.00	
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00	
		Y/N	IME Average	Direct GME Average		
		1.00	2.00	3.00		
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00	61.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00			62.00	
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00			62.01	
Teaching Hospitals that Claim Residents in Non-Provider Settings						
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete lines 64-67. (see instructions)	N			63.00	
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
		1.00	2.00	3.00		
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	64.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))
		1.00	2.00	3.00	4.00	5.00
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	0	0.00	0.00	0.000000

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		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	0	0.00	0.00	0.000000 67.00	
				1.00	2.00	3.00	
Inpatient Psychiatric Facility PPS							
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N			70.00
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)					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	N		91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.					N	92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	N		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	N		94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.			0.00		0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.			N	N		96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.			0.00		0.00	97.00

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			V	XIX	
			1.00	2.00	
Rural Providers					
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?		N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)		N		106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)		N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		N		108.00
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	Y	Y	Y	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.			1	118.00
119.00	What is the liability limit for the malpractice insurance policy? Enter in column 1 the monetary limit per lawsuit. Enter in column 2 the monetary limit per policy year.		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		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:	Contractor's Name:		Contractor's Number:	
142.00	Street:	PO Box:			
143.00	City:	State:		Zip Code:	
				1.00	
144.00	Are provider based physicians' costs included in Worksheet A?		Y		144.00
145.00	If costs for renal services are claimed on Worksheet A, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.		Y		145.00

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		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								
165.00	Multi campus Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.				N		165.00						
		Name		County		State		Zip Code		CBSA		FTE/Campus	
		0		1.00		2.00		3.00		4.00		5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5											0.00	
					1.00								
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act													
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.				Y						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		
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)										1.00		

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 150175	Period: From 10/01/2010 To 09/30/2011	Worksheet S-2 Part II Date/Time Prepared: 2/28/2012 3:03 pm	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.		N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)		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.		Y		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)		N		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)		Y		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 150175

Period:
From 10/01/2010
To 09/30/2011

Worksheet S-2
Part II
Date/Time Prepared:
2/28/2012 3:03 pm

		Part A		
		Description	Y/N	Date
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	0	1.00 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 relieved for Medicare purposes? If yes, see instructions			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.			23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			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.			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			29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			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.			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.			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.			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.			35.00
				Y/N
				Date
				1.00
				2.00
Home Office Costs				
36.00	Were home office costs claimed on the cost report?			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.			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.			38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			40.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 150175

Period:
From 10/01/2010
To 09/30/2011

Worksheet S-2
Part II
Date/Time Prepared:
2/28/2012 3:03 pm

		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)	N		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)	Y		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: 150175

Period:
From 10/01/2010
To 09/30/2011

Worksheet S-3
Part I
Date/Time Prepared:
2/28/2012 3:03 pm

Cost Center Description	Worksheet A	No. of Beds	Bed Days Available	CAH Hours		
	Line Number					
	1.00	2.00	3.00	4.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	24	8,760	0.00		1.00
2.00 HMO						2.00
3.00 HMO IPF						3.00
4.00 HMO IRF						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		24	8,760	0.00		7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		24	8,760	0.00		14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		24				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: 150175

Period:
From 10/01/2010
To 09/30/2011

Worksheet S-3
Part I
Date/Time Prepared:
2/28/2012 3:03 pm

Cost Center Description	I/P Days / O/P Visits / Trips					
	Title V	Title XVIII	Title XIX	Total All Patients		
	5.00	6.00	7.00	8.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	0	3,194	189	5,887		1.00
2.00 HMO		694	44			2.00
3.00 HMO IPF		0	0			3.00
4.00 HMO IRF		0	0			4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0	0		5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0	0	0	0		6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	0	3,194	189	5,887		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	3,194	189	5,887		14.00
15.00 CAH visits	0	0	0	0		15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)						27.00
28.00 Observation Bed Days	0		48	993		28.00
29.00 Ambulance Trips		0				29.00
30.00 Employee discount days (see instruction)				40		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: 150175

Period:
From 10/01/2010
To 09/30/2011

Worksheet S-3
Part I
Date/Time Prepared:
2/28/2012 3:03 pm

Cost Center Description	Full Time Equivalents			Discharges		
	Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	
	9.00	10.00	11.00	12.00	13.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)				0	856	1.00
2.00 HMO					172	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	120.45	0.00	0	856	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)	0.00	120.45	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: 150175

Period:
From 10/01/2010
To 09/30/2011

Worksheet S-3
Part I
Date/Time Prepared:
2/28/2012 3:03 pm

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)	44	1,630		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)	44	1,630		14.00
15.00 CAH visits				15.00
16.00 SUBPROVIDER - IPF				16.00
17.00 SUBPROVIDER - IRF				17.00
18.00 SUBPROVIDER				18.00
19.00 SKILLED NURSING FACILITY				19.00
20.00 NURSING FACILITY				20.00
21.00 OTHER LONG TERM CARE				21.00
22.00 HOME HEALTH AGENCY				22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)				23.00
24.00 HOSPICE				24.00
25.00 CMHC - CMHC				25.00
26.00 RURAL HEALTH CLINIC				26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER				26.25
27.00 Total (sum of lines 14-26)				27.00
28.00 Observation Bed Days				28.00
29.00 Ambulance Trips				29.00
30.00 Employee discount days (see instruction)				30.00
31.00 Employee discount days - IRF				31.00
32.00 Labor & delivery days (see instructions)				32.00
33.00 LTCH non-covered days				33.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150175

Period:
From 10/01/2010
To 09/30/2011

Worksheet S-3
Part II
Date/Time Prepared:
2/28/2012 3:03 pm

	Worksheet A Line Number	Amount Reported	Salary Adjustments for Vacation, Holiday, Sick, Other Paid Time Off, Severance, and Bonus, Paid to Employees and Not Reflected in Column 2	Recl assi fi cation of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	
	1.00	2.00	2.50	3.00	4.00	
PART II - WAGE DATA						
SALARIES						
1.00	Total salaries (see instructions)	200.00	6,255,990	0	327,247	6,583,237 1.00
2.00	Non-physician anesthetist Part A		0	0	0	0 2.00
3.00	Non-physician anesthetist Part B		0	0	0	0 3.00
4.00	Physician-Part A		0	0	0	0 4.00
4.01	Physicians - Part A - direct teaching		0	0	0	0 4.01
5.00	Physician-Part B		0	0	0	0 5.00
6.00	Non-physician-Part B		0	0	0	0 6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0 7.00
7.01	Contracted interns and residents (in approved programs)		0	0	0	0 7.01
8.00	Home office personnel		0	0	0	0 8.00
9.00	SNF	44.00	0	0	0	0 9.00
10.00	Excluded area salaries (see instructions)		0	0	0	0 10.00
OTHER WAGES & RELATED COSTS						
11.00	Contract labor (see instructions)		318,602	0	0	318,602 11.00
12.00	Management and administrative services		0	0	0	0 12.00
13.00	Contract labor: physician-Part A		895	0	0	895 13.00
14.00	Home office salaries & wage-related costs		0	0	0	0 14.00
15.00	Home office: physician Part A		0	0	0	0 15.00
16.00	Teaching physician salaries (see instructions)		0	0	0	0 16.00
WAGE-RELATED COSTS						
17.00	Wage-related costs (core) Wkst S-3, Part IV Line 24		1,859,960	0	0	1,859,960 17.00
18.00	Wage-related costs (other) Wkst S-3, Part IV Line 25		0	0	0	0 18.00
19.00	Excluded areas		0	0	0	0 19.00
20.00	Non-physician anesthetist Part A		0	0	0	0 20.00
21.00	Non-physician anesthetist Part B		0	0	0	0 21.00
22.00	Physician Part A		0	0	0	0 22.00
23.00	Physician Part B		0	0	0	0 23.00
24.00	Wage-related costs (RHC/FOHC)		0	0	0	0 24.00
25.00	Interns & residents (in an approved program)		0	0	0	0 25.00
OVERHEAD COSTS - DIRECT SALARIES						
26.00	Employee Benefits	4.00	0	0	0	0 26.00
27.00	Administrative & General	5.00	415,302	0	5,927	421,229 27.00
28.00	Administrative & General under contract (see inst.)		69,133	0	0	69,133 28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0 29.00
30.00	Operation of Plant	7.00	0	0	0	0 30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0 31.00
32.00	Housekeeping	9.00	0	0	0	0 32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0 33.00
34.00	Dietary	10.00	0	0	0	0 34.00
35.00	Dietary under contract (see instructions)		0	0	0	0 35.00
36.00	Cafeteria	11.00	0	0	0	0 36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0 37.00
38.00	Nursing Administration	13.00	0	0	0	0 38.00
39.00	Central Services and Supply	14.00	0	0	0	0 39.00
40.00	Pharmacy	15.00	0	0	0	0 40.00
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0 41.00
42.00	Social Service	17.00	0	0	0	0 42.00
43.00	Other General Service	18.00	0	0	0	0 43.00

HOSPITAL WAGE INDEX INFORMATION		Provider CCN: 150175	Period: From 10/01/2010 To 09/30/2011	Worksheet S-3 Part II Date/Time Prepared: 2/28/2012 3:03 pm
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		Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		5.00	6.00	
PART II - WAGE DATA				
SALARIES				
1.00	Total salaries (see instructions)	243,978.00	26.98	1.00
2.00	Non-physician anesthetist Part A	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B	0.00	0.00	3.00
4.00	Physician-Part A	0.00	0.00	4.00
4.01	Physicians - Part A - direct teaching	0.00	0.00	4.01
5.00	Physician-Part B	0.00	0.00	5.00
6.00	Non-physician-Part B	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	0.00	0.00	7.00
7.01	Contracted interns and residents (in approved programs)	0.00	0.00	7.01
8.00	Home office personnel	0.00	0.00	8.00
9.00	SNF	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)	0.00	0.00	10.00
OTHER WAGES & RELATED COSTS				
11.00	Contract labor (see instructions)	1,700.00	187.41	11.00
12.00	Management and administrative services	0.00	0.00	12.00
13.00	Contract labor: physician-Part A	5.25	170.48	13.00
14.00	Home office salaries & wage-related costs	0.00	0.00	14.00
15.00	Home office: physician Part A	0.00	0.00	15.00
16.00	Teaching physician salaries (see instructions)	0.00	0.00	16.00
WAGE-RELATED COSTS				
17.00	Wage-related costs (core) Wkst S-3, Part IV Line 24			17.00
18.00	Wage-related costs (other) Wkst S-3, Part IV Line 25			18.00
19.00	Excluded areas			19.00
20.00	Non-physician anesthetist Part A			20.00
21.00	Non-physician anesthetist Part B			21.00
22.00	Physician Part A			22.00
23.00	Physician Part B			23.00
24.00	Wage-related costs (RHC/FQHC)			24.00
25.00	Interns & residents (in an approved program)			25.00
OVERHEAD COSTS - DIRECT SALARIES				
26.00	Employee Benefits	0.00	0.00	26.00
27.00	Administrative & General	11,557.00	36.45	27.00
28.00	Administrative & General under contract (see inst.)	217.00	318.59	28.00
29.00	Maintenance & Repairs	0.00	0.00	29.00
30.00	Operation of Plant	0.00	0.00	30.00
31.00	Laundry & Linen Service	0.00	0.00	31.00
32.00	Housekeeping	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)	0.00	0.00	33.00
34.00	Dietary	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)	0.00	0.00	35.00
36.00	Cafeteria	0.00	0.00	36.00
37.00	Maintenance of Personnel	0.00	0.00	37.00
38.00	Nursing Administration	0.00	0.00	38.00
39.00	Central Services and Supply	0.00	0.00	39.00
40.00	Pharmacy	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	0.00	0.00	41.00
42.00	Social Service	0.00	0.00	42.00
43.00	Other General Service	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150175

Period:
From 10/01/2010
To 09/30/2011

Worksheet S-3
Part III
Date/Time Prepared:
2/28/2012 3:03 pm

	Worksheet A Line Number	Amount Reported	Salary Adjustments for Vacation, Holiday, Sick, Other Paid Time Off, Severance, and Bonus, Paid to Employees and Not Reflected in Column 2	Recl assi fi cation of Sal aries (from Worksheet A-6)	Adjusted Sal aries (col . 2 ± col . 3)	
	1.00	2.00	2.50	3.00	4.00	
PART III - HOSPITAL WAGE INDEX SUMMARY						
1.00	Net salaries (see instructions)	6,325,123	0	327,247	6,652,370	1.00
2.00	Excluded area salaries (see instructions)	0	0	0	0	2.00
3.00	Subtotal salaries (line 1 minus line 2)	6,325,123	0	327,247	6,652,370	3.00
4.00	Subtotal other wages & related costs (see inst.)	319,497	0	0	319,497	4.00
5.00	Subtotal wage-related costs (see inst.)	1,859,960	0	0	1,859,960	5.00
6.00	Total (sum of lines 3 thru 5)	8,504,580	0	327,247	8,831,827	6.00
7.00	Total overhead cost (see instructions)	484,435	0	5,927	490,362	7.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150175

Period:
From 10/01/2010
To 09/30/2011

Worksheet S-3
Part III
Date/Time Prepared:
2/28/2012 3:03 pm

		Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY				
1.00	Net salaries (see instructions)	244,195.00	27.24	1.00
2.00	Excluded area salaries (see instructions)	0.00	0.00	2.00
3.00	Subtotal salaries (line 1 minus line 2)	244,195.00	27.24	3.00
4.00	Subtotal other wages & related costs (see inst.)	1,705.25	187.36	4.00
5.00	Subtotal wage-related costs (see inst.)	0.00	27.96	5.00
6.00	Total (sum of lines 3 thru 5)	245,900.25	35.92	6.00
7.00	Total overhead cost (see instructions)	11,774.00	41.65	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 150175	Period: From 10/01/2010 To 09/30/2011	Worksheet S-3 Part IV Date/Time Prepared: 2/28/2012 3:03 pm
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions			86,163 1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution			0 2.00
3.00	Qualified and Non-Qualified Pension Plan Cost			229,438 3.00
4.00	Prior Year Pension Service Cost			0 4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration Fees			1,298 5.00
6.00	Legal/Accounting/Management Fees-Pension Plan			6,814 6.00
7.00	Employee Managed Care Program Administration Fees			0 7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)			858,976 8.00
9.00	Prescription Drug Plan			0 9.00
10.00	Dental, Hearing and Vision Plan			30,921 10.00
11.00	Life Insurance (If employee is owner or beneficiary)			4,934 11.00
12.00	Accident Insurance (If employee is owner or beneficiary)			68 12.00
13.00	Disability Insurance (If employee is owner or beneficiary)			57,685 13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)			0 14.00
15.00	'Workers' Compensation Insurance			45,296 15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)			0 16.00
TAXES				
17.00	FICA-Employers Portion Only			490,086 17.00
18.00	Medicare Taxes - Employers Portion Only			0 18.00
19.00	Unemployment Insurance			12,376 19.00
20.00	State or Federal Unemployment Taxes			0 20.00
OTHER				
21.00	Executive Deferred Compensation			13,437 21.00
22.00	Day Care Cost and Allowances			5,269 22.00
23.00	Tuition Reimbursement			17,197 23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)			1,859,958 24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)			0 25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 150175	Period: From 10/01/2010 To 09/30/2011	Worksheet S-3 Part V Date/Time Prepared: 2/28/2012 3:03 pm
Cost Center Description			Contract Labor	Benefit Cost
PART V - Contract Labor and Benefit Cost			1.00	2.00
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost		387,735	0 1.00
2.00	Hospital		387,735	0 2.00
3.00	Subprovider - IPF			0 3.00
4.00	Subprovider - IRF			0 4.00
5.00	Subprovider - (Other)		0	0 5.00
6.00	Swing Beds - SNF		0	0 6.00
7.00	Swing Beds - NF		0	0 7.00
8.00	Hospital-Based SNF			0 8.00
9.00	Hospital-Based NF			0 9.00
10.00	Hospital-Based OLTC			0 10.00
11.00	Hospital-Based HHA			0 11.00
12.00	Separately Certified ASC			0 12.00
13.00	Hospital-Based Hospice			0 13.00
14.00	Hospital-Based Health Clinic RHC			0 14.00
15.00	Hospital-Based Health Clinic FQHC			0 15.00
16.00	Hospital-Based-CMHC			0 16.00
17.00	Renal Dialysis		0	0 17.00
18.00			0	0 18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 150175	Period: From 10/01/2010 To 09/30/2011	Worksheet S-10 Date/Time Prepared: 2/28/2012 3:03 pm
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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)		0.285967	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		465,715	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		3,379,830	6.00	
7.00	Medicaid cost (line 1 times line 6)		966,520	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)		500,805	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		0	18.00	
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		500,805	19.00	
			Uninsured patients	Insured patients	
			1.00	2.00	
			Total (col. 1 + col. 2)		
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	2,112,218	105,776	2,217,994	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	604,025	30,248	634,273	21.00
22.00	Partial payment by patients approved for charity care	4,750	0	4,750	22.00
23.00	Cost of charity care (line 21 minus line 22)	599,275	30,248	629,523	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?		N	24.00	
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit		0	25.00	
26.00	Total bad debt expense for the entire hospital complex (see instructions)		1,854,816	26.00	
27.00	Medicare bad debts for the entire hospital complex (see instructions)		78,307	27.00	
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)		1,776,509	28.00	
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)		508,023	29.00	
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)		1,137,546	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		1,638,351	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES			Provider CCN: 150175	Period: From 10/01/2010 To 09/30/2011	Worksheet A Date/Time Prepared: 2/28/2012 3:03 pm	
Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
	1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT		0	0	1,596,514	1,596,514	1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP		0	0	1,761,798	1,761,798	2.00
4.00 EMPLOYEE BENEFITS	0	2,350,895	2,350,895	0	2,350,895	4.00
5.00 ADMINISTRATIVE & GENERAL	415,302	6,845,992	7,261,294	-3,036,733	4,224,561	5.00
7.00 OPERATION OF PLANT	0	418,719	418,719	0	418,719	7.00
8.00 LAUNDRY & LINEN SERVICE	0	62,402	62,402	0	62,402	8.00
9.00 HOUSEKEEPING	0	159,612	159,612	0	159,612	9.00
10.00 DIETARY	0	229,708	229,708	0	229,708	10.00
11.00 CAFETERIA	0	0	0	0	0	11.00
13.00 NURSING ADMINISTRATION	0	57,791	57,791	-285	57,506	13.00
14.00 CENTRAL SERVICES & SUPPLY	0	230,387	230,387	-71,286	159,101	14.00
15.00 PHARMACY	0	1,971,116	1,971,116	-1,456,994	514,122	15.00
16.00 MEDICAL RECORDS & LIBRARY	0	484,186	484,186	0	484,186	16.00
17.00 SOCIAL SERVICE	0	200,037	200,037	0	200,037	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	2,779,086	414,281	3,193,367	-202,608	2,990,759	30.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	444,446	4,451,082	4,895,528	-2,981,907	1,913,621	50.00
54.00 RADIOLOGY-DIAGNOSTIC	0	587,619	587,619	0	587,619	54.00
59.00 CARDIAC CATHETERIZATION	2,100,282	10,127,840	12,228,122	-9,415,701	2,812,421	59.00
60.00 LABORATORY	0	1,344,491	1,344,491	0	1,344,491	60.00
64.00 INTRAVENOUS THERAPY	108,553	14,134	122,687	-90,866	31,821	64.00
65.00 RESPIRATORY THERAPY	0	129,437	129,437	0	129,437	65.00
66.00 PHYSICAL THERAPY	0	86,678	86,678	0	86,678	66.00
69.00 ELECTROCARDIOLOGY	144,853	84,562	229,415	-25,332	204,083	69.00
69.01 CARDIAC REHAB	215,936	52,493	268,429	-15,098	253,331	69.01
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	3,727,423	3,727,423	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	8,761,609	8,761,609	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	1,458,220	1,458,220	73.00
74.00 RENAL DIALYSIS	47,532	54,637	102,169	-8,754	93,415	74.00
76.00 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1-117)	6,255,990	30,358,099	36,614,089	0	36,614,089	118.00
NONREIMBURSABLE COST CENTERS						
194.00 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01 VISITOR ASSISTANTS	0	22,425	22,425	0	22,425	194.01
194.02 PUBLIC RELATIONS	0	10,300	10,300	0	10,300	194.02
200.00 TOTAL (SUM OF LINES 118-199)	6,255,990	30,390,824	36,646,814	0	36,646,814	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150175

Period:
From 10/01/2010
To 09/30/2011

Worksheet A
Date/Time Prepared:
2/28/2012 3:03 pm

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
		6.00	7.00	
GENERAL SERVICE COST CENTERS				
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	1,596,514	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	1,761,798	2.00
4.00	EMPLOYEE BENEFITS	-732,150	1,618,745	4.00
5.00	ADMINISTRATIVE & GENERAL	-787,325	3,437,236	5.00
7.00	OPERATION OF PLANT	0	418,719	7.00
8.00	LAUNDRY & LINEN SERVICE	31,954	94,356	8.00
9.00	HOUSEKEEPING	0	159,612	9.00
10.00	DIETARY	-13,487	216,221	10.00
11.00	CAFETERIA	57,297	57,297	11.00
13.00	NURSING ADMINISTRATION	0	57,506	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	159,101	14.00
15.00	PHARMACY	0	514,122	15.00
16.00	MEDICAL RECORDS & LIBRARY	-132,136	352,050	16.00
17.00	SOCIAL SERVICE	0	200,037	17.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	0	2,990,759	30.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	-1,040,055	873,566	50.00
54.00	RADIOLOGY-DIAGNOSTIC	-50,470	537,149	54.00
59.00	CARDIAC CATHETERIZATION	-80,000	2,732,421	59.00
60.00	LABORATORY	102,829	1,447,320	60.00
64.00	INTRAVENOUS THERAPY	0	31,821	64.00
65.00	RESPIRATORY THERAPY	205,924	335,361	65.00
66.00	PHYSICAL THERAPY	-43,969	42,709	66.00
69.00	ELECTROCARDIOLOGY	-55,664	148,419	69.00
69.01	CARDIAC REHAB	5,408	258,739	69.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	99,003	3,826,426	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	8,761,609	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	1,458,220	73.00
74.00	RENAL DIALYSIS	-483	92,932	74.00
76.00	OTHER ANCILLARY SERVICE COST CENTERS	2,897	2,897	76.00
OUTPATIENT SERVICE COST CENTERS				
92.00	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
SPECIAL PURPOSE COST CENTERS				
118.00	SUBTOTALS (SUM OF LINES 1-117)	-2,430,427	34,183,662	118.00
NONREIMBURSABLE COST CENTERS				
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.00
194.01	VISITOR ASSISTANTS	0	22,425	194.01
194.02	PUBLIC RELATIONS	0	10,300	194.02
200.00	TOTAL (SUM OF LINES 118-199)	-2,430,427	34,216,387	200.00

RECLASSIFICATIONS

Provider CCN: 150175

Period:
From 10/01/2010
To 09/30/2011

Worksheet A-6

Date/Time Prepared:
2/28/2012 3:03 pm

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - EQUIPMENT DEPRECIATION					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	527,035	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
	TOTALS		0	527,035	
B - LEASES					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1,571,776	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	1,162,169	2.00
	TOTALS		0	2,733,945	
C - INSURANCE					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	24,738	1.00
	TOTALS		0	24,738	
D - PROPERTY TAXES					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	72,594	1.00
	TOTALS		0	72,594	
E - MEDICAL SUPPLIES AND DRUGS CHARGED					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	3,727,423	1.00
2.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	8,761,609	2.00
3.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,458,220	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
	TOTALS		0	13,947,252	
F - MEDICAL DIRECTORSHIPS					
1.00	CARDIAC CATHETERIZATION	59.00	0	80,000	1.00
2.00	RENAL DIALYSIS	74.00	0	895	2.00
	TOTALS		0	80,895	
G - INCENTIVE COMP					
1.00	ADMINISTRATIVE & GENERAL	5.00	5,927	0	1.00
2.00	ADULTS & PEDIATRICS	30.00	60,185	0	2.00
3.00	OPERATING ROOM	50.00	8,187	0	3.00
4.00	CARDIAC CATHETERIZATION	59.00	37,144	0	4.00
5.00	INTRAVENOUS THERAPY	64.00	1,711	0	5.00
6.00	ELECTROCARDIOLOGY	69.00	7,353	0	6.00
7.00	CARDIAC REHAB	69.01	5,937	0	7.00
8.00	RENAL DIALYSIS	74.00	803	0	8.00
	TOTALS		127,247	0	
H - SALARIES					
1.00	ELECTROCARDIOLOGY	69.00	200,000	0	1.00
	TOTALS		200,000	0	
500.00	Grand Total: Increases		327,247	17,386,459	500.00

RECLASSIFICATIONS

Provider CCN: 150175

Period:
From 10/01/2010
To 09/30/2011

Worksheet A-6
Date/Time Prepared:
2/28/2012 3:03 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - EQUIPMENT DEPRECIATION							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	3,241	9		1.00
2.00	NURSING ADMINISTRATION	13.00	0	285	9		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	115,493	9		3.00
4.00	OPERATING ROOM	50.00	0	177,283	9		4.00
5.00	CARDIAC CATHETERIZATION	59.00	0	191,997	9		5.00
6.00	ELECTROCARDIOLOGY	69.00	0	12,267	9		6.00
7.00	CARDIAC REHAB	69.01	0	16,017	9		7.00
8.00	RENAL DIALYSIS	74.00	0	10,452	9		8.00
	TOTALS		0	527,035			
B - LEASES							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	2,733,945	10		1.00
2.00		0.00	0	0	10		2.00
	TOTALS		0	2,733,945			
C - INSURANCE							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	24,738	12		1.00
	TOTALS		0	24,738			
D - PROPERTY TAXES							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	72,594	13		1.00
	TOTALS		0	72,594			
E - MEDICAL SUPPLIES AND DRUGS CHARGED							
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	71,286	0		1.00
2.00	PHARMACY	15.00	0	1,456,994	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	147,300	0		3.00
4.00	OPERATING ROOM	50.00	0	2,812,811	0		4.00
5.00	CARDIAC CATHETERIZATION	59.00	0	9,340,848	0		5.00
6.00	INTRAVENOUS THERAPY	64.00	0	92,577	0		6.00
7.00	ELECTROCARDIOLOGY	69.00	0	20,418	0		7.00
8.00	CARDIAC REHAB	69.01	0	5,018	0		8.00
	TOTALS		0	13,947,252			
F - MEDICAL DIRECTORSHIPS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	80,895	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	80,895			
G - INCENTIVE COMP							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	127,247	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
	TOTALS		0	127,247			
H - SALARIES							
1.00	ELECTROCARDIOLOGY	69.00	0	200,000	0		1.00
	TOTALS		0	200,000			
500.00	Grand Total: Decreases		0	17,713,706			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150175

Period:
From 10/01/2010
To 09/30/2011

Worksheet A-7
Parts I-III
Date/Time Prepared:
2/28/2012 3:03 pm

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	3.00
4.00	Building Improvements	0	0	0	0	4.00
5.00	Fixed Equipment	3,753,281	1,520,940	0	1,520,940	5.00
6.00	Movable Equipment	0	0	0	0	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	3,753,281	1,520,940	0	1,520,940	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	3,753,281	1,520,940	0	1,520,940	10.00
SUMMARY OF CAPITAL						
Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
	9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	3.00
COMPUTATION OF RATIOS						
Cost Center Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL Ratio (see instructions)	Insurance	
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1.000000	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1.000000	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150175

Period:
From 10/01/2010
To 09/30/2011

Worksheet A-7
Parts I-III
Date/Time Prepared:
2/28/2012 3:03 pm

		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	0	0			3.00
4.00	Building Improvements	0	0			4.00
5.00	Fixed Equipment	5,274,221	0			5.00
6.00	Movable Equipment	0	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	5,274,221	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	5,274,221	0			10.00
SUMMARY OF CAPITAL						
Cost Center Description		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)			
		14.00	15.00			
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0			1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0			2.00
3.00	Total (sum of lines 1-2)	0	0			3.00
ALLOCATION OF OTHER CAPITAL						
Cost Center Description		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL Depreciation	Lease
		6.00	7.00	8.00	9.00	10.00
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	1,571,776
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	527,035	1,162,169
3.00	Total (sum of lines 1-2)	0	0	0	527,035	2,733,945

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150175

Period:
From 10/01/2010
To 09/30/2011

Worksheet A-7
Parts I-III
Date/Time Prepared:
2/28/2012 3:03 pm

Cost Center Description	SUMMARY OF CAPITAL					Total (2) (sum of cols. 9 through 14)	
	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
	11.00	12.00	13.00	14.00	15.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	24,738	0	0	1,596,514	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	72,594	0	1,761,798	2.00
3.00	Total (sum of lines 1-2)	0	24,738	72,594	0	3,358,312	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 150175

Period:
From 10/01/2010
To 09/30/2011

Worksheet A-8
Date/Time Prepared:
2/28/2012 3:03 pm

				Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted	
		Basis/Code (2)	Amount	Cost Center	Line #
		1.00	2.00	3.00	4.00
1.00	Investment income - buildings and fixtures (chapter 2)			NEW CAP REL COSTS-BLDG & FIXT	1.00
2.00	Investment income - movable equipment (chapter 2)			NEW CAP REL COSTS-MVBLE EQUIP	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	A-8-2	-136,147		10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		11.00
12.00	Related organization transactions (chapter 10)	A-8-1	-1,121,764		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)	A-8-3		RESPIRATORY THERAPY	65.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		PHYSICAL THERAPY	66.00
25.00	Utilization review - physicians' compensation (chapter 21)			*** Cost Center Deleted ***	114.00
26.00	Depreciation - buildings and fixtures			NEW CAP REL COSTS-BLDG & FIXT	1.00
27.00	Depreciation - movable equipment			NEW CAP REL COSTS-MVBLE EQUIP	2.00
28.00	Non-physician Anesthetist			*** Cost Center Deleted ***	19.00
29.00	Physicians' assistant				29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		*** Cost Center Deleted ***	67.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		*** Cost Center Deleted ***	68.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		32.00
33.00	NON-PATIENT REVENUE	B	-1,264	ADMINISTRATIVE & GENERAL	5.00
34.00	SELF INSURANCE	A	-732,150	EMPLOYEE BENEFITS	4.00
35.00	RESEARCH	A	-439,102	ADMINISTRATIVE & GENERAL	5.00
36.00	OTHER ADJUSTMENTS (SPECIFY)		0		36.00
37.00	OTHER ADJUSTMENTS (SPECIFY)		0		37.00
38.00	OTHER ADJUSTMENTS (SPECIFY)		0		38.00
39.00	OTHER ADJUSTMENTS (SPECIFY)		0		39.00
40.00	OTHER ADJUSTMENTS (SPECIFY)		0		40.00
41.00	OTHER ADJUSTMENTS (SPECIFY)		0		41.00
42.00	OTHER ADJUSTMENTS (SPECIFY)		0		42.00
43.00	OTHER ADJUSTMENTS (SPECIFY)		0		43.00
44.00	OTHER ADJUSTMENTS (SPECIFY)		0		44.00
45.00	OTHER ADJUSTMENTS (SPECIFY)		0		45.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,430,427		50.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 150175

Period:
From 10/01/2010
To 09/30/2011

Worksheet A-8

Date/Time Prepared:
2/28/2012 3:03 pm

		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	NON-PATIENT REVENUE	0	33.00
34.00	SELF INSURANCE	0	34.00
35.00	RESEARCH	0	35.00
36.00	OTHER ADJUSTMENTS (SPECIFY)	0	36.00
37.00	OTHER ADJUSTMENTS (SPECIFY)	0	37.00
38.00	OTHER ADJUSTMENTS (SPECIFY)	0	38.00
39.00	OTHER ADJUSTMENTS (SPECIFY)	0	39.00
40.00	OTHER ADJUSTMENTS (SPECIFY)	0	40.00
41.00	OTHER ADJUSTMENTS (SPECIFY)	0	41.00
42.00	OTHER ADJUSTMENTS (SPECIFY)	0	42.00
43.00	OTHER ADJUSTMENTS (SPECIFY)	0	43.00
44.00	OTHER ADJUSTMENTS (SPECIFY)	0	44.00
45.00	OTHER ADJUSTMENTS (SPECIFY)	0	45.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		50.00

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

Provider CCN: 150175

Period: From 10/01/2010 To 09/30/2011

Worksheet A-8-1

Date/Time Prepared: 2/28/2012 3:03 pm

	Line No.	Cost Center	Expense Items	
	1.00	2.00	3.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	1.00	NEW CAP REL COSTS-BLDG & FIXT	BUILDING LEASE	1.00
2.00	2.00	NEW CAP REL COSTS-MVBLE EQUIP	LEASES	2.00
3.00	4.00	EMPLOYEE BENEFITS	BENEFITS	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	CONTRACT SERVICES	4.00
4.01	7.00	OPERATION OF PLANT	CONTRACT SERVICES	4.01
4.02	8.00	LAUNDRY & LINEN SERVICE	CONTRACT SERVICES	4.02
4.03	9.00	HOUSEKEEPING	CONTRACT SERVICES	4.03
4.04	10.00	DIETARY	CONTRACT SERVICES	4.04
4.05	11.00	CAFETERIA	CONTRACT SERVICES	4.05
4.06	13.00	NURSING ADMINISTRATION	CONTRACT SERVICES	4.06
4.07	14.00	CENTRAL SERVICES & SUPPLY	CONTRACT SERVICES	4.07
4.08	15.00	PHARMACY	CONTRACT SERVICES	4.08
4.09	16.00	MEDICAL RECORDS & LIBRARY	CONTRACT SERVICES	4.09
4.10	17.00	SOCIAL SERVICE	CONTRACT SERVICES	4.10
4.11	30.00	ADULTS & PEDIATRICS	CONTRACT SERVICES	4.11
4.12	50.00	OPERATING ROOM	CONTRACT SERVICES	4.12
4.13	54.00	RADIOLOGY-DIAGNOSTIC	CONTRACT SERVICES	4.13
4.14	59.00	CARDIAC CATHETERIZATION	CONTRACT SERVICES	4.14
4.15	60.00	LABORATORY	CONTRACT SERVICES	4.15
4.16	64.00	INTRAVENOUS THERAPY	CONTRACT SERVICES	4.16
4.17	65.00	RESPIRATORY THERAPY	CONTRACT SERVICES	4.17
4.18	69.00	ELECTROCARDIOLOGY	CONTRACT SERVICES	4.18
4.19	69.01	CARDIAC REHAB	CONTRACT SERVICES	4.19
4.20	71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	CONTRACT SERVICES	4.20
4.21	74.00	RENAL DIALYSIS	CONTRACT SERVICES	4.21
4.22	76.00	OTHER ANCILLARY SERVICE COST CENTERS	CONTRACT SERVICES	4.22
4.23	69.01	CARDIAC REHAB	FACILITY RENT	4.23
4.24	66.00	PHYSICAL THERAPY	THERAPY SERVICES	4.24
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			5.00

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

	Symbol (1)	Name	Percentage of Ownership	
	1.00	2.00	3.00	
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:				

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

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

6.00	B		51.00	6.00
7.00	B		51.00	7.00
8.00	B		51.00	8.00
9.00	B		51.00	9.00
10.00	B		51.00	10.00
10.01	B		51.00	10.01
10.02	B		51.00	10.02
10.03	B		51.00	10.03
10.04	B		51.00	10.04
10.05	B		51.00	10.05
10.06	B		51.00	10.06
10.07	B		51.00	10.07
10.08	B		51.00	10.08
10.09	B		51.00	10.09
10.10	B		51.00	10.10
10.11	B		51.00	10.11
10.12	B		51.00	10.12
10.13	B		51.00	10.13
10.14	B		51.00	10.14
10.15	B		51.00	10.15
10.16	B		51.00	10.16
10.17	B		51.00	10.17
10.18	B		51.00	10.18

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

Provider CCN: 150175

Period:
From 10/01/2010
To 09/30/2011

Worksheet A-8-1

Date/Time Prepared:
2/28/2012 3:03 pm

		Symbol (1)	Name	Percentage of Ownership	
		1.00	2.00	3.00	
10.19		B		51.00	10.19
10.20		B		51.00	10.20
10.21		B		51.00	10.21
10.22		B		0.00	10.22
10.23		A		0.00	10.23
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.

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

Provider CCN: 150175

Period: From 10/01/2010 To 09/30/2011

Worksheet A-8-1

Date/Time Prepared: 2/28/2012 3:03 pm

	Amount of Allowable Cost	Amount Included in Wks. A, column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00	1,571,776	1,571,776	0	10		1.00
2.00	1,162,169	1,162,169	0	10		2.00
3.00	2,338,751	2,338,751	0	0		3.00
4.00	2,683,005	3,029,964	-346,959	0		4.00
4.01	143,633	143,633	0	0		4.01
4.02	94,356	62,402	31,954	0		4.02
4.03	159,612	159,612	0	0		4.03
4.04	216,221	229,708	-13,487	0		4.04
4.05	57,297	0	57,297	0		4.05
4.06	57,506	57,506	0	0		4.06
4.07	112,828	112,828	0	0		4.07
4.08	512,083	512,083	0	0		4.08
4.09	352,050	484,186	-132,136	0		4.09
4.10	129,734	129,734	0	0		4.10
4.11	2,806,281	2,806,281	0	0		4.11
4.12	487,552	1,527,607	-1,040,055	0		4.12
4.13	449,034	499,504	-50,470	0		4.13
4.14	2,186,769	2,186,769	0	0		4.14
4.15	1,447,320	1,344,491	102,829	0		4.15
4.16	24,206	24,206	0	0		4.16
4.17	335,362	129,438	205,924	0		4.17
4.18	66,287	66,287	0	0		4.18
4.19	214,026	214,026	0	0		4.19
4.20	99,003	0	99,003	0		4.20
4.21	47,532	47,532	0	0		4.21
4.22	2,897	0	2,897	0		4.22
4.23	51,199	45,791	5,408	0		4.23
4.24	42,718	86,687	-43,969	0		4.24
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.	17,851,207	18,972,971	-1,121,764		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	DEACONESS HOSPITAL	0.00	HOSPITAL	6.00
7.00	DEACONESS HOSPITAL	0.00	HOSPITAL	7.00
8.00	DEACONESS HOSPITAL	0.00	HOSPITAL	8.00
9.00	DEACONESS HOSPITAL	0.00	HOSPITAL	9.00
10.00	DEACONESS HOSPITAL	0.00	HOSPITAL	10.00
10.01	DEACONESS HOSPITAL	0.00	HOSPITAL	10.01
10.02	DEACONESS HOSPITAL	0.00	HOSPITAL	10.02
10.03	DEACONESS HOSPITAL	0.00	HOSPITAL	10.03
10.04	DEACONESS HOSPITAL	0.00	HOSPITAL	10.04
10.05	DEACONESS HOSPITAL	0.00	HOSPITAL	10.05
10.06	DEACONESS HOSPITAL	0.00	HOSPITAL	10.06
10.07	DEACONESS HOSPITAL	0.00	HOSPITAL	10.07
10.08	DEACONESS HOSPITAL	0.00	HOSPITAL	10.08
10.09	DEACONESS HOSPITAL	0.00	HOSPITAL	10.09
10.10	DEACONESS HOSPITAL	0.00	HOSPITAL	10.10
10.11	DEACONESS HOSPITAL	0.00	HOSPITAL	10.11
10.12	DEACONESS HOSPITAL	0.00	HOSPITAL	10.12
10.13	DEACONESS HOSPITAL	0.00	HOSPITAL	10.13
10.14	DEACONESS HOSPITAL	0.00	HOSPITAL	10.14
10.15	DEACONESS HOSPITAL	0.00	HOSPITAL	10.15

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

Provider CCN: 150175

Period:
From 10/01/2010
To 09/30/2011

Worksheet A-8-1

Date/Time Prepared:
2/28/2012 3:03 pm

		Related Organization(s) and/or Home Office			
		Name	Percentage of Ownership	Type of Business	
		4.00	5.00	6.00	
10.16		DEACONESS HOSPITAL	0.00	HOSPITAL	10.16
10.17		DEACONESS HOSPITAL	0.00	HOSPITAL	10.17
10.18		DEACONESS HOSPITAL	0.00	HOSPITAL	10.18
10.19		DEACONESS HOSPITAL	0.00	HOSPITAL	10.19
10.20		DEACONESS HOSPITAL	0.00	HOSPITAL	10.20
10.21		DEACONESS HOSPITAL	0.00	HOSPITAL	10.21
10.22		DEAC HEALTH SYS	0.00	HEALTH SYSTEM	10.22
10.23		PROGRESSIVE HEA	51.00	THERAPY PROVIDE	10.23
100.00	G. Other (financial or non-financial) specify:				100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 150175

Period:
From 10/01/2010
To 09/30/2011

Worksheet A-8-2

Date/Time Prepared:
2/28/2012 3:03 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
	1.00	2.00	3.00	4.00	
1.00	59.00	CARDIOLOGY	80,000	80,000	1.00
2.00	69.00	EKG	55,664	55,664	2.00
3.00	74.00	DIALYSIS	895	0	3.00
4.00	0.00		0	0	4.00
5.00	0.00		0	0	5.00
6.00	0.00		0	0	6.00
7.00	0.00		0	0	7.00
8.00	0.00		0	0	8.00
9.00	0.00		0	0	9.00
10.00	0.00		0	0	10.00
200.00		TOTAL (lines 1.00 through 199.00)	136,559	135,664	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 150175

Period:
From 10/01/2010
To 09/30/2011

Worksheet A-8-2

Date/Time Prepared:
2/28/2012 3:03 pm

	Provider Component	RCE Amount	Physician/Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	5.00	6.00	7.00	8.00	9.00	
1.00	0	171,400	0	0	0	1.00
2.00	0	171,400	0	0	0	2.00
3.00	895	171,400	5	412	21	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	895		5	412	21	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 150175

Period:
From 10/01/2010
To 09/30/2011

Worksheet A-8-2

Date/Time Prepared:
2/28/2012 3:03 pm

	Cost of Memberships & Continuing Education 12.00	Provider Component Share of col. 12 13.00	Physician Cost of Malpractice Insurance 14.00	Provider Component Share of col. 14 15.00	Adjusted RCE Limit 16.00	
1.00	0	0	0	0	0	1.00
2.00	0	0	0	0	0	2.00
3.00	0	0	0	0	412	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	412	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 150175

Period:
From 10/01/2010
To 09/30/2011

Worksheet A-8-2

Date/Time Prepared:
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	RCE	Adjustment	
	Disallowance		
	17.00	18.00	
1.00	0	80,000	1.00
2.00	0	55,664	2.00
3.00	483	483	3.00
4.00	0	0	4.00
5.00	0	0	5.00
6.00	0	0	6.00
7.00	0	0	7.00
8.00	0	0	8.00
9.00	0	0	9.00
10.00	0	0	10.00
200.00	483	136,147	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150175

Period:
From 10/01/2010
To 09/30/2011

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT	1,596,514	1,596,514				1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	1,761,798		1,761,798			2.00
4.00 EMPLOYEE BENEFITS	1,618,745	0	0	1,618,745		4.00
5.00 ADMINISTRATIVE & GENERAL	3,437,236	46,237	10,834	103,576	3,597,883	5.00
7.00 OPERATION OF PLANT	418,719	5,438	0	0	424,157	7.00
8.00 LAUNDRY & LINEN SERVICE	94,356	0	0	0	94,356	8.00
9.00 HOUSEKEEPING	159,612	8,209	0	0	167,821	9.00
10.00 DIETARY	216,221	0	0	0	216,221	10.00
11.00 CAFETERIA	57,297	0	0	0	57,297	11.00
13.00 NURSING ADMINISTRATION	57,506	0	953	0	58,459	13.00
14.00 CENTRAL SERVICES & SUPPLY	159,101	0	0	0	159,101	14.00
15.00 PHARMACY	514,122	0	0	0	514,122	15.00
16.00 MEDICAL RECORDS & LIBRARY	352,050	0	0	0	352,050	16.00
17.00 SOCIAL SERVICE	200,037	0	0	0	200,037	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	2,990,759	764,070	386,076	698,144	4,839,049	30.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	873,566	248,691	592,630	111,297	1,826,184	50.00
54.00 RADIOLOGY-DIAGNOSTIC	537,149	0	0	0	537,149	54.00
59.00 CARDIAC CATHETERIZATION	2,732,421	523,869	641,817	525,570	4,423,677	59.00
60.00 LABORATORY	1,447,320	0	0	0	1,447,320	60.00
64.00 INTRAVENOUS THERAPY	31,821	0	0	27,113	58,934	64.00
65.00 RESPIRATORY THERAPY	335,361	0	0	0	335,361	65.00
66.00 PHYSICAL THERAPY	42,709	0	0	0	42,709	66.00
69.00 ELECTROCARDIOLOGY	148,419	0	41,007	86,604	276,030	69.00
69.01 CARDIAC REHAB	258,739	0	53,542	54,556	366,837	69.01
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	3,826,426	0	0	0	3,826,426	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	8,761,609	0	0	0	8,761,609	72.00
73.00 DRUGS CHARGED TO PATIENTS	1,458,220	0	0	0	1,458,220	73.00
74.00 RENAL DIALYSIS	92,932	0	34,939	11,885	139,756	74.00
76.00 OTHER ANCILLARY SERVICE COST CENTERS	2,897	0	0	0	2,897	76.00
OUTPATIENT SERVICE COST CENTERS						
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						0
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1-117)	34,183,662	1,596,514	1,761,798	1,618,745	34,183,662	118.00
NONREIMBURSABLE COST CENTERS						
194.00 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01 VISITOR ASSISTANTS	22,425	0	0	0	22,425	194.01
194.02 PUBLIC RELATIONS	10,300	0	0	0	10,300	194.02
200.00 Cross Foot Adjustments						0
201.00 Negative Cost Centers		0	0	0		0
202.00 TOTAL (sum lines 118-201)	34,216,387	1,596,514	1,761,798	1,618,745	34,216,387	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150175

Period:
From 10/01/2010
To 09/30/2011

Worksheet B
Part I
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Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
	5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 EMPLOYEE BENEFITS						4.00
5.00 ADMINISTRATIVE & GENERAL	3,597,883					5.00
7.00 OPERATION OF PLANT	49,841	473,998				7.00
8.00 LAUNDRY & LINEN SERVICE	11,087	0	105,443			8.00
9.00 HOUSEKEEPING	19,720	2,519	0	190,060		9.00
10.00 DIETARY	25,407	0	0	0	241,628	10.00
11.00 CAFETERIA	6,733	0	0	0	0	11.00
13.00 NURSING ADMINISTRATION	6,869	0	0	0	0	13.00
14.00 CENTRAL SERVICES & SUPPLY	18,695	0	0	0	0	14.00
15.00 PHARMACY	60,413	0	0	0	0	15.00
16.00 MEDICAL RECORDS & LIBRARY	41,368	0	0	0	0	16.00
17.00 SOCIAL SERVICE	23,506	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	568,622	234,437	65,467	94,505	230,629	30.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	214,589	76,305	16,376	30,760	0	50.00
54.00 RADIOLOGY-DIAGNOSTIC	63,119	0	0	0	0	54.00
59.00 CARDIAC CATHETERIZATION	519,813	160,737	23,600	64,795	10,999	59.00
60.00 LABORATORY	170,070	0	0	0	0	60.00
64.00 INTRAVENOUS THERAPY	6,925	0	0	0	0	64.00
65.00 RESPIRATORY THERAPY	39,407	0	0	0	0	65.00
66.00 PHYSICAL THERAPY	5,019	0	0	0	0	66.00
69.00 ELECTROCARDIOLOGY	32,435	0	0	0	0	69.00
69.01 CARDIAC REHAB	43,106	0	0	0	0	69.01
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	449,632	0	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	1,029,549	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	171,351	0	0	0	0	73.00
74.00 RENAL DIALYSIS	16,422	0	0	0	0	74.00
76.00 OTHER ANCILLARY SERVICE COST CENTERS	340	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1-117)	3,594,038	473,998	105,443	190,060	241,628	118.00
NONREIMBURSABLE COST CENTERS						
194.00 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01 VISITOR ASSISTANTS	2,635	0	0	0	0	194.01
194.02 PUBLIC RELATIONS	1,210	0	0	0	0	194.02
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	3,597,883	473,998	105,443	190,060	241,628	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 150175		Period: From 10/01/2010 To 09/30/2011		Worksheet B Part I Date/Time Prepared: 2/28/2012 3:03 pm	
Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
7.00	OPERATION OF PLANT						7.00
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING						9.00
10.00	DIETARY						10.00
11.00	CAFETERIA	64,030					11.00
13.00	NURSING ADMINISTRATION	0	65,328				13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	177,796			14.00
15.00	PHARMACY	0	0	0	574,535		15.00
16.00	MEDICAL RECORDS & LIBRARY	0	0	0	0	393,418	16.00
17.00	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	31,737	30,107	0	0	36,083	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	4,343	4,099	0	0	30,447	50.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	13,649	54.00
59.00	CARDIAC CATHETERIZATION	19,599	18,581	0	0	138,285	59.00
60.00	LABORATORY	0	0	0	0	22,569	60.00
64.00	INTRAVENOUS THERAPY	891	859	0	0	276	64.00
65.00	RESPIRATORY THERAPY	0	0	0	0	3,557	65.00
66.00	PHYSICAL THERAPY	0	0	0	0	1,585	66.00
69.00	ELECTROCARDIOLOGY	3,897	0	0	0	18,335	69.00
69.01	CARDIAC REHAB	3,118	4,099	0	0	3,099	69.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	53,064	0	45,531	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	124,732	0	48,702	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	574,535	30,797	73.00
74.00	RENAL DIALYSIS	445	7,583	0	0	490	74.00
76.00	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	13	76.00
OUTPATIENT SERVICE COST CENTERS							
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	64,030	65,328	177,796	574,535	393,418	118.00
NONREIMBURSABLE COST CENTERS							
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	VISITOR ASSISTANTS	0	0	0	0	0	194.01
194.02	PUBLIC RELATIONS	0	0	0	0	0	194.02
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	64,030	65,328	177,796	574,535	393,418	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150175

Period:
From 10/01/2010
To 09/30/2011

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00 NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00 EMPLOYEE BENEFITS					4.00
5.00 ADMINISTRATIVE & GENERAL					5.00
7.00 OPERATION OF PLANT					7.00
8.00 LAUNDRY & LINEN SERVICE					8.00
9.00 HOUSEKEEPING					9.00
10.00 DIETARY					10.00
11.00 CAFETERIA					11.00
13.00 NURSING ADMINISTRATION					13.00
14.00 CENTRAL SERVICES & SUPPLY					14.00
15.00 PHARMACY					15.00
16.00 MEDICAL RECORDS & LIBRARY					16.00
17.00 SOCIAL SERVICE	223,543				17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 ADULTS & PEDIATRICS	213,368	6,344,004	0	6,344,004	30.00
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	0	2,203,103	0	2,203,103	50.00
54.00 RADIOLOGY-DIAGNOSTIC	0	613,917	0	613,917	54.00
59.00 CARDIAC CATHETERIZATION	10,175	5,390,261	0	5,390,261	59.00
60.00 LABORATORY	0	1,639,959	0	1,639,959	60.00
64.00 INTRAVENOUS THERAPY	0	67,885	0	67,885	64.00
65.00 RESPIRATORY THERAPY	0	378,325	0	378,325	65.00
66.00 PHYSICAL THERAPY	0	49,313	0	49,313	66.00
69.00 ELECTROCARDIOLOGY	0	330,697	0	330,697	69.00
69.01 CARDIAC REHAB	0	420,259	0	420,259	69.01
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,374,653	0	4,374,653	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	9,964,592	0	9,964,592	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	2,234,903	0	2,234,903	73.00
74.00 RENAL DIALYSIS	0	164,696	0	164,696	74.00
76.00 OTHER ANCILLARY SERVICE COST CENTERS	0	3,250	0	3,250	76.00
OUTPATIENT SERVICE COST CENTERS					
92.00 OBSERVATION BEDS (NON-DISTINCT PART)			0		92.00
SPECIAL PURPOSE COST CENTERS					
118.00 SUBTOTALS (SUM OF LINES 1-117)	223,543	34,179,817	0	34,179,817	118.00
NONREIMBURSABLE COST CENTERS					
194.00 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.00
194.01 VISITOR ASSISTANTS	0	25,060	0	25,060	194.01
194.02 PUBLIC RELATIONS	0	11,510	0	11,510	194.02
200.00 Cross Foot Adjustments		0	0	0	200.00
201.00 Negative Cost Centers	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	223,543	34,216,387	0	34,216,387	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150175

Period:
From 10/01/2010
To 09/30/2011

Worksheet B
Part II
Date/Time Prepared:
2/28/2012 3:03 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	2.00			
GENERAL SERVICE COST CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	EMPLOYEE BENEFITS	0	0	0	0	4.00
5.00	ADMINISTRATIVE & GENERAL	0	46,237	10,834	57,071	5.00
7.00	OPERATION OF PLANT	0	5,438	0	5,438	7.00
8.00	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00	HOUSEKEEPING	0	8,209	0	8,209	9.00
10.00	DIETARY	0	0	0	0	10.00
11.00	CAFETERIA	0	0	0	0	11.00
13.00	NURSING ADMINISTRATION	0	0	953	953	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00	PHARMACY	0	0	0	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	0	0	0	0	16.00
17.00	SOCIAL SERVICE	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	0	764,070	386,076	1,150,146	30.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	248,691	592,630	841,321	50.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
59.00	CARDIAC CATHETERIZATION	0	523,869	641,817	1,165,686	59.00
60.00	LABORATORY	0	0	0	0	60.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	0	0	66.00
69.00	ELECTROCARDIOLOGY	0	0	41,007	41,007	69.00
69.01	CARDIAC REHAB	0	0	53,542	53,542	69.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	RENAL DIALYSIS	0	0	34,939	34,939	74.00
76.00	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
92.00	OBSERVATION BEDS (NON-DISTINCT PART)				0	92.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	1,596,514	1,761,798	3,358,312	118.00
NONREIMBURSABLE COST CENTERS						
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.00
194.01	VISITOR ASSISTANTS	0	0	0	0	194.01
194.02	PUBLIC RELATIONS	0	0	0	0	194.02
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	1,596,514	1,761,798	3,358,312	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150175			Period: From 10/01/2010 To 09/30/2011		Worksheet B Part II Date/Time Prepared: 2/28/2012 3:03 pm	
Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY		
		5.00	7.00	8.00	9.00	10.00		
GENERAL SERVICE COST CENTERS								
1.00	NEW CAP REL COSTS-BLDG & FIXT							1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP							2.00
4.00	EMPLOYEE BENEFITS							4.00
5.00	ADMINISTRATIVE & GENERAL	57,071						5.00
7.00	OPERATION OF PLANT	791	6,229					7.00
8.00	LAUNDRY & LINEN SERVICE	176	0	176				8.00
9.00	HOUSEKEEPING	313	33	0	8,555			9.00
10.00	DIETARY	403	0	0	0	403		10.00
11.00	CAFETERIA	107	0	0	0	0		11.00
13.00	NURSING ADMINISTRATION	109	0	0	0	0		13.00
14.00	CENTRAL SERVICES & SUPPLY	297	0	0	0	0		14.00
15.00	PHARMACY	958	0	0	0	0		15.00
16.00	MEDICAL RECORDS & LIBRARY	656	0	0	0	0		16.00
17.00	SOCIAL SERVICE	373	0	0	0	0		17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	9,020	3,081	110	4,253	385		30.00
ANCILLARY SERVICE COST CENTERS								
50.00	OPERATING ROOM	3,404	1,003	27	1,385	0		50.00
54.00	RADIOLOGY-DIAGNOSTIC	1,001	0	0	0	0		54.00
59.00	CARDIAC CATHETERIZATION	8,246	2,112	39	2,917	18		59.00
60.00	LABORATORY	2,698	0	0	0	0		60.00
64.00	INTRAVENOUS THERAPY	110	0	0	0	0		64.00
65.00	RESPIRATORY THERAPY	625	0	0	0	0		65.00
66.00	PHYSICAL THERAPY	80	0	0	0	0		66.00
69.00	ELECTROCARDIOLOGY	515	0	0	0	0		69.00
69.01	CARDIAC REHAB	684	0	0	0	0		69.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,132	0	0	0	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	16,328	0	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	2,718	0	0	0	0		73.00
74.00	RENAL DIALYSIS	261	0	0	0	0		74.00
76.00	OTHER ANCILLARY SERVICE COST CENTERS	5	0	0	0	0		76.00
OUTPATIENT SERVICE COST CENTERS								
92.00	OBSERVATION BEDS (NON-DISTINCT PART)							92.00
SPECIAL PURPOSE COST CENTERS								
118.00	SUBTOTALS (SUM OF LINES 1-117)	57,010	6,229	176	8,555	403		118.00
NONREIMBURSABLE COST CENTERS								
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0		194.00
194.01	VISITOR ASSISTANTS	42	0	0	0	0		194.01
194.02	PUBLIC RELATIONS	19	0	0	0	0		194.02
200.00	Cross Foot Adjustments							200.00
201.00	Negative Cost Centers	0	0	0	0	0		201.00
202.00	TOTAL (sum lines 118-201)	57,071	6,229	176	8,555	403		202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150175		Period: From 10/01/2010 To 09/30/2011		Worksheet B Part II Date/Time Prepared: 2/28/2012 3:03 pm	
Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
7.00	OPERATION OF PLANT						7.00
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING						9.00
10.00	DIETARY						10.00
11.00	CAFETERIA	107					11.00
13.00	NURSING ADMINISTRATION	0	1,062				13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	297			14.00
15.00	PHARMACY	0	0	0	958		15.00
16.00	MEDICAL RECORDS & LIBRARY	0	0	0	0	656	16.00
17.00	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	53	489	0	0	56	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	7	67	0	0	47	50.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	21	54.00
59.00	CARDIAC CATHETERIZATION	33	302	0	0	259	59.00
60.00	LABORATORY	0	0	0	0	35	60.00
64.00	INTRAVENOUS THERAPY	1	14	0	0	0	64.00
65.00	RESPIRATORY THERAPY	0	0	0	0	6	65.00
66.00	PHYSICAL THERAPY	0	0	0	0	2	66.00
69.00	ELECTROCARDIOLOGY	7	0	0	0	29	69.00
69.01	CARDIAC REHAB	5	67	0	0	5	69.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	89	0	71	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	208	0	76	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	958	48	73.00
74.00	RENAL DIALYSIS	1	123	0	0	1	74.00
76.00	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	107	1,062	297	958	656	118.00
NONREIMBURSABLE COST CENTERS							
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	VISITOR ASSISTANTS	0	0	0	0	0	194.01
194.02	PUBLIC RELATIONS	0	0	0	0	0	194.02
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	107	1,062	297	958	656	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150175		Period: From 10/01/2010 To 09/30/2011		Worksheet B Part II Date/Time Prepared: 2/28/2012 3:03 pm	
Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total			
	17.00	24.00	25.00	26.00			
GENERAL SERVICE COST CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
7.00	OPERATION OF PLANT						7.00
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING						9.00
10.00	DIETARY						10.00
11.00	CAFETERIA						11.00
13.00	NURSING ADMINISTRATION						13.00
14.00	CENTRAL SERVICES & SUPPLY						14.00
15.00	PHARMACY						15.00
16.00	MEDICAL RECORDS & LIBRARY						16.00
17.00	SOCIAL SERVICE	373					17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	356	1,167,949	0	1,167,949		30.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	0	847,261	0	847,261		50.00
54.00	RADIOLOGY-DIAGNOSTIC	0	1,022	0	1,022		54.00
59.00	CARDIAC CATHETERIZATION	17	1,179,629	0	1,179,629		59.00
60.00	LABORATORY	0	2,733	0	2,733		60.00
64.00	INTRAVENOUS THERAPY	0	125	0	125		64.00
65.00	RESPIRATORY THERAPY	0	631	0	631		65.00
66.00	PHYSICAL THERAPY	0	82	0	82		66.00
69.00	ELECTROCARDIOLOGY	0	41,558	0	41,558		69.00
69.01	CARDIAC REHAB	0	54,303	0	54,303		69.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	7,292	0	7,292		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	16,612	0	16,612		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	3,724	0	3,724		73.00
74.00	RENAL DIALYSIS	0	35,325	0	35,325		74.00
76.00	OTHER ANCILLARY SERVICE COST CENTERS	0	5	0	5		76.00
OUTPATIENT SERVICE COST CENTERS							
92.00	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	373	3,358,251	0	3,358,251		118.00
NONREIMBURSABLE COST CENTERS							
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0		194.00
194.01	VISITOR ASSISTANTS	0	42	0	42		194.01
194.02	PUBLIC RELATIONS	0	19	0	19		194.02
200.00	Cross Foot Adjustments		0	0	0		200.00
201.00	Negative Cost Centers	0	0	0	0		201.00
202.00	TOTAL (sum lines 118-201)	373	3,358,312	0	3,358,312		202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150175

Period:
From 10/01/2010
To 09/30/2011

Worksheet B-1
Date/Time Prepared:
2/28/2012 3:03 pm

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DEPRECIATION COST)					
	1.00	2.00	4.00				
GENERAL SERVICE COST CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	45,509					1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP		527,035				2.00
4.00	EMPLOYEE BENEFITS	0	0	6,583,237			4.00
5.00	ADMINISTRATIVE & GENERAL	1,318	3,241	421,229	-3,597,883	30,618,504	5.00
7.00	OPERATION OF PLANT	155	0	0	0	424,157	7.00
8.00	LAUNDRY & LINEN SERVICE	0	0	0	0	94,356	8.00
9.00	HOUSEKEEPING	234	0	0	0	167,821	9.00
10.00	DIETARY	0	0	0	0	216,221	10.00
11.00	CAFETERIA	0	0	0	0	57,297	11.00
13.00	NURSING ADMINISTRATION	0	285	0	0	58,459	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	0	0	159,101	14.00
15.00	PHARMACY	0	0	0	0	514,122	15.00
16.00	MEDICAL RECORDS & LIBRARY	0	0	0	0	352,050	16.00
17.00	SOCIAL SERVICE	0	0	0	0	200,037	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	21,780	115,493	2,839,271	0	4,839,049	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	7,089	177,283	452,633	0	1,826,184	50.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	537,149	54.00
59.00	CARDIAC CATHETERIZATION	14,933	191,997	2,137,426	0	4,423,677	59.00
60.00	LABORATORY	0	0	0	0	1,447,320	60.00
64.00	INTRAVENOUS THERAPY	0	0	110,264	0	58,934	64.00
65.00	RESPIRATORY THERAPY	0	0	0	0	335,361	65.00
66.00	PHYSICAL THERAPY	0	0	0	0	42,709	66.00
69.00	ELECTROCARDIOLOGY	0	12,267	352,206	0	276,030	69.00
69.01	CARDIAC REHAB	0	16,017	221,873	0	366,837	69.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	3,826,426	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	8,761,609	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,458,220	73.00
74.00	RENAL DIALYSIS	0	10,452	48,335	0	139,756	74.00
76.00	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	2,897	76.00
OUTPATIENT SERVICE COST CENTERS							
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	45,509	527,035	6,583,237	-3,597,883	30,585,779	118.00
NONREIMBURSABLE COST CENTERS							
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	VISITOR ASSISTANTS	0	0	0	0	22,425	194.01
194.02	PUBLIC RELATIONS	0	0	0	0	10,300	194.02
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	1,596,514	1,761,798	1,618,745		3,597,883	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	35.081281	3.342848	0.245889		0.117507	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			0		57,071	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000000		0.001864	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150175

Period:
From 10/01/2010
To 09/30/2011

Worksheet B-1

Date/Time Prepared:
2/28/2012 3:03 pm

Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	
	7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 EMPLOYEE BENEFITS						4.00
5.00 ADMINISTRATIVE & GENERAL						5.00
7.00 OPERATION OF PLANT	44,036					7.00
8.00 LAUNDRY & LINEN SERVICE	0	127,798				8.00
9.00 HOUSEKEEPING	234	0	43,802			9.00
10.00 DIETARY	0	0	0	24,166		10.00
11.00 CAFETERIA	0	0	0	0	1,150	11.00
13.00 NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00 PHARMACY	0	0	0	0	0	15.00
16.00 MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00 SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	21,780	79,347	21,780	23,066	570	30.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	7,089	19,848	7,089	0	78	50.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
59.00 CARDIAC CATHETERIZATION	14,933	28,603	14,933	1,100	352	59.00
60.00 LABORATORY	0	0	0	0	0	60.00
64.00 INTRAVENOUS THERAPY	0	0	0	0	16	64.00
65.00 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00 ELECTROCARDIOLOGY	0	0	0	0	70	69.00
69.01 CARDIAC REHAB	0	0	0	0	56	69.01
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	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	8	74.00
76.00 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1-117)	44,036	127,798	43,802	24,166	1,150	118.00
NONREIMBURSABLE COST CENTERS						
194.00 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01 VISITOR ASSISTANTS	0	0	0	0	0	194.01
194.02 PUBLIC RELATIONS	0	0	0	0	0	194.02
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	473,998	105,443	190,060	241,628	64,030	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	10.763875	0.825076	4.339071	9.998676	55.678261	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	6,229	176	8,555	403	107	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)	0.141452	0.001377	0.195311	0.016676	0.093043	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150175

Period:
From 10/01/2010
To 09/30/2011

Worksheet B-1
Date/Time Prepared:
2/28/2012 3:03 pm

Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	
	(DIRECT NRSING HRS)	(COSTED REQUIS.)		(TIME SPENT)	(TIME SPENT)	
	13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS						
1.00 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 EMPLOYEE BENEFITS						4.00
5.00 ADMINISTRATIVE & GENERAL						5.00
7.00 OPERATION OF PLANT						7.00
8.00 LAUNDRY & LINEN SERVICE						8.00
9.00 HOUSEKEEPING						9.00
10.00 DIETARY						10.00
11.00 CAFETERIA						11.00
13.00 NURSING ADMINISTRATION	257,098					13.00
14.00 CENTRAL SERVICES & SUPPLY	0	12,489,032				14.00
15.00 PHARMACY	0	0	1,458,220			15.00
16.00 MEDICAL RECORDS & LIBRARY	0	0	0	122,725,742		16.00
17.00 SOCIAL SERVICE	0	0	0	0	7,250	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	118,491	0	0	11,254,808	6,920	30.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	16,130	0	0	9,496,814	0	50.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	4,257,197	0	54.00
59.00 CARDIAC CATHETERIZATION	73,125	0	0	43,146,007	330	59.00
60.00 LABORATORY	0	0	0	7,039,754	0	60.00
64.00 INTRAVENOUS THERAPY	3,380	0	0	85,963	0	64.00
65.00 RESPIRATORY THERAPY	0	0	0	1,109,504	0	65.00
66.00 PHYSICAL THERAPY	0	0	0	494,302	0	66.00
69.00 ELECTROCARDIOLOGY	0	0	0	5,718,909	0	69.00
69.01 CARDIAC REHAB	16,130	0	0	966,708	0	69.01
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,727,423	0	14,201,874	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	8,761,609	0	15,190,744	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	1,458,220	9,606,175	0	73.00
74.00 RENAL DIALYSIS	29,842	0	0	152,802	0	74.00
76.00 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	4,181	0	76.00
OUTPATIENT SERVICE COST CENTERS						
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1-117)	257,098	12,489,032	1,458,220	122,725,742	7,250	118.00
NONREIMBURSABLE COST CENTERS						
194.00 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01 VISITOR ASSISTANTS	0	0	0	0	0	194.01
194.02 PUBLIC RELATIONS	0	0	0	0	0	194.02
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	65,328	177,796	574,535	393,418	223,543	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	0.254098	0.014236	0.393997	0.003206	30.833517	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	1,062	297	958	656	373	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)	0.004131	0.000024	0.000657	0.000005	0.051448	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150175

Period:
From 10/01/2010
To 09/30/2011

Worksheet C
Part I
Date/Time Prepared:
2/28/2012 3:03 pm

		Title XVIII		Hospital		PPS	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE Disallowance	Total Costs		
	1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	6,344,004		6,344,004	0	6,344,004	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	2,203,103		2,203,103	0	2,203,103	50.00
54.00	RADIOLOGY-DIAGNOSTIC	613,917		613,917	0	613,917	54.00
59.00	CARDIAC CATHETERIZATION	5,390,261		5,390,261	0	5,390,261	59.00
60.00	LABORATORY	1,639,959		1,639,959	0	1,639,959	60.00
64.00	INTRAVENOUS THERAPY	67,885		67,885	0	67,885	64.00
65.00	RESPIRATORY THERAPY	378,325	0	378,325	0	378,325	65.00
66.00	PHYSICAL THERAPY	49,313	0	49,313	0	49,313	66.00
69.00	ELECTROCARDIOLOGY	330,697		330,697	0	330,697	69.00
69.01	CARDIAC REHAB	420,259		420,259	0	420,259	69.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,374,653		4,374,653	0	4,374,653	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	9,964,592		9,964,592	0	9,964,592	72.00
73.00	DRUGS CHARGED TO PATIENTS	2,234,903		2,234,903	0	2,234,903	73.00
74.00	RENAL DIALYSIS	164,696		164,696	483	165,179	74.00
76.00	OTHER ANCILLARY SERVICE COST CENTERS	3,250		3,250	0	3,250	76.00
OUTPATIENT SERVICE COST CENTERS							
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	915,635		915,635		915,635	92.00
200.00	Subtotal (see instructions)	35,095,452	0	35,095,452	483	35,095,935	200.00
201.00	Less Observation Beds	915,635		915,635		915,635	201.00
202.00	Total (see instructions)	34,179,817	0	34,179,817	483	34,180,300	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150175

Period:
From 10/01/2010
To 09/30/2011

Worksheet C
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Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
Title XVIII Hospital PPS						
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	10,008,105		10,008,105			30.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	9,171,544	325,270	9,496,814	0.231983	0.000000	50.00
54.00 RADIOLOGY-DIAGNOSTIC	1,997,030	2,260,168	4,257,198	0.144207	0.000000	54.00
59.00 CARDIAC CATHETERIZATION	14,145,719	28,719,136	42,864,855	0.125750	0.000000	59.00
60.00 LABORATORY	5,684,158	1,355,595	7,039,753	0.232957	0.000000	60.00
64.00 INTRAVENOUS THERAPY	85,522	441	85,963	0.789700	0.000000	64.00
65.00 RESPIRATORY THERAPY	1,088,033	21,471	1,109,504	0.340986	0.000000	65.00
66.00 PHYSICAL THERAPY	485,934	8,368	494,302	0.099763	0.000000	66.00
69.00 ELECTROCARDIOLOGY	1,855,751	3,863,158	5,718,909	0.057825	0.000000	69.00
69.01 CARDIAC REHAB	0	966,708	966,708	0.434732	0.000000	69.01
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	8,829,498	5,372,376	14,201,874	0.308034	0.000000	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	4,748,863	10,441,880	15,190,743	0.655965	0.000000	72.00
73.00 DRUGS CHARGED TO PATIENTS	7,350,928	2,536,399	9,887,327	0.226037	0.000000	73.00
74.00 RENAL DIALYSIS	148,719	4,085	152,804	1.077825	0.000000	74.00
76.00 OTHER ANCILLARY SERVICE COST CENTERS	3,060	1,121	4,181	0.777326	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS						
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	284,613	962,089	1,246,702	0.734446	0.000000	92.00
200.00 Subtotal (see instructions)	65,887,477	56,838,265	122,725,742			200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	65,887,477	56,838,265	122,725,742			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150175	Period: From 10/01/2010 To 09/30/2011	Worksheet C Part I Date/Time Prepared: 2/28/2012 3:03 pm
		Title XVIII	Hospital	PPS
Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS			30.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0.231983		50.00
54.00	RADIOLOGY-DIAGNOSTIC	0.144207		54.00
59.00	CARDIAC CATHETERIZATION	0.125750		59.00
60.00	LABORATORY	0.232957		60.00
64.00	INTRAVENOUS THERAPY	0.789700		64.00
65.00	RESPIRATORY THERAPY	0.340986		65.00
66.00	PHYSICAL THERAPY	0.099763		66.00
69.00	ELECTROCARDIOLOGY	0.057825		69.00
69.01	CARDIAC REHAB	0.434732		69.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.308034		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.655965		72.00
73.00	DRUGS CHARGED TO PATIENTS	0.226037		73.00
74.00	RENAL DIALYSIS	1.080986		74.00
76.00	OTHER ANCILLARY SERVICE COST CENTERS	0.777326		76.00
OUTPATIENT SERVICE COST CENTERS				
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.734446		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: 150175

Period:
From 10/01/2010
To 09/30/2011

Worksheet C
Part I
Date/Time Prepared:
2/28/2012 3:03 pm

		Title XIX		Hospital		PPS	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE Disallowance	Total Costs		
	1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	6,344,004		6,344,004	0	6,344,004	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	2,203,103		2,203,103	0	2,203,103	50.00
54.00	RADIOLOGY-DIAGNOSTIC	613,917		613,917	0	613,917	54.00
59.00	CARDIAC CATHETERIZATION	5,390,261		5,390,261	0	5,390,261	59.00
60.00	LABORATORY	1,639,959		1,639,959	0	1,639,959	60.00
64.00	INTRAVENOUS THERAPY	67,885		67,885	0	67,885	64.00
65.00	RESPIRATORY THERAPY	378,325	0	378,325	0	378,325	65.00
66.00	PHYSICAL THERAPY	49,313	0	49,313	0	49,313	66.00
69.00	ELECTROCARDIOLOGY	330,697		330,697	0	330,697	69.00
69.01	CARDIAC REHAB	420,259		420,259	0	420,259	69.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,374,653		4,374,653	0	4,374,653	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	9,964,592		9,964,592	0	9,964,592	72.00
73.00	DRUGS CHARGED TO PATIENTS	2,234,903		2,234,903	0	2,234,903	73.00
74.00	RENAL DIALYSIS	164,696		164,696	483	165,179	74.00
76.00	OTHER ANCILLARY SERVICE COST CENTERS	3,250		3,250	0	3,250	76.00
OUTPATIENT SERVICE COST CENTERS							
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	915,635		915,635		915,635	92.00
200.00	Subtotal (see instructions)	35,095,452	0	35,095,452	483	35,095,935	200.00
201.00	Less Observation Beds	915,635		915,635		915,635	201.00
202.00	Total (see instructions)	34,179,817	0	34,179,817	483	34,180,300	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150175

Period:
From 10/01/2010
To 09/30/2011

Worksheet C
Part I
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Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
Title XIX Hospital PPS						
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	10,008,105		10,008,105			30.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	9,171,544	325,270	9,496,814	0.231983	0.000000	50.00
54.00 RADIOLOGY-DIAGNOSTIC	1,997,030	2,260,168	4,257,198	0.144207	0.000000	54.00
59.00 CARDIAC CATHETERIZATION	14,145,719	28,719,136	42,864,855	0.125750	0.000000	59.00
60.00 LABORATORY	5,684,158	1,355,595	7,039,753	0.232957	0.000000	60.00
64.00 INTRAVENOUS THERAPY	85,522	441	85,963	0.789700	0.000000	64.00
65.00 RESPIRATORY THERAPY	1,088,033	21,471	1,109,504	0.340986	0.000000	65.00
66.00 PHYSICAL THERAPY	485,934	8,368	494,302	0.099763	0.000000	66.00
69.00 ELECTROCARDIOLOGY	1,855,751	3,863,158	5,718,909	0.057825	0.000000	69.00
69.01 CARDIAC REHAB	0	966,708	966,708	0.434732	0.000000	69.01
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	8,829,498	5,372,376	14,201,874	0.308034	0.000000	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	4,748,863	10,441,880	15,190,743	0.655965	0.000000	72.00
73.00 DRUGS CHARGED TO PATIENTS	7,350,928	2,536,399	9,887,327	0.226037	0.000000	73.00
74.00 RENAL DIALYSIS	148,719	4,085	152,804	1.077825	0.000000	74.00
76.00 OTHER ANCILLARY SERVICE COST CENTERS	3,060	1,121	4,181	0.777326	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS						
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	284,613	962,089	1,246,702	0.734446	0.000000	92.00
200.00 Subtotal (see instructions)	65,887,477	56,838,265	122,725,742			200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	65,887,477	56,838,265	122,725,742			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150175	Period: From 10/01/2010 To 09/30/2011	Worksheet C Part I Date/Time Prepared: 2/28/2012 3:03 pm
		Title XIX	Hospital	PPS
Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS			30.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0.231983		50.00
54.00	RADIOLOGY-DIAGNOSTIC	0.144207		54.00
59.00	CARDIAC CATHETERIZATION	0.125750		59.00
60.00	LABORATORY	0.232957		60.00
64.00	INTRAVENOUS THERAPY	0.789700		64.00
65.00	RESPIRATORY THERAPY	0.340986		65.00
66.00	PHYSICAL THERAPY	0.099763		66.00
69.00	ELECTROCARDIOLOGY	0.057825		69.00
69.01	CARDIAC REHAB	0.434732		69.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.308034		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.655965		72.00
73.00	DRUGS CHARGED TO PATIENTS	0.226037		73.00
74.00	RENAL DIALYSIS	1.080986		74.00
76.00	OTHER ANCILLARY SERVICE COST CENTERS	0.777326		76.00
OUTPATIENT SERVICE COST CENTERS				
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.734446		92.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

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

Provider CCN: 150175

Period: From 10/01/2010 To 09/30/2011

Worksheet C Part II Date/Time Prepared: 2/28/2012 3:03 pm

Cost Center Description		Title XIX			Hospital		PPS
		Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	2,203,103	847,261	1,355,842	0	0	50.00
54.00	RADIOLOGY-DIAGNOSTIC	613,917	1,022	612,895	0	0	54.00
59.00	CARDIAC CATHETERIZATION	5,390,261	1,179,629	4,210,632	0	0	59.00
60.00	LABORATORY	1,639,959	2,733	1,637,226	0	0	60.00
64.00	INTRAVENOUS THERAPY	67,885	125	67,760	0	0	64.00
65.00	RESPIRATORY THERAPY	378,325	631	377,694	0	0	65.00
66.00	PHYSICAL THERAPY	49,313	82	49,231	0	0	66.00
69.00	ELECTROCARDIOLOGY	330,697	41,558	289,139	0	0	69.00
69.01	CARDIAC REHAB	420,259	54,303	365,956	0	0	69.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,374,653	7,292	4,367,361	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	9,964,592	16,612	9,947,980	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	2,234,903	3,724	2,231,179	0	0	73.00
74.00	RENAL DIALYSIS	164,696	35,325	129,371	0	0	74.00
76.00	OTHER ANCILLARY SERVICE COST CENTERS	3,250	5	3,245	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	915,635	168,571	747,064	0	0	92.00
200.00	Subtotal (sum of lines 50 thru 199)	28,751,448	2,358,873	26,392,575	0	0	200.00
201.00	Less Observation Beds	915,635	168,571	747,064	0	0	201.00
202.00	Total (line 200 minus line 201)	27,835,813	2,190,302	25,645,511	0	0	202.00

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

Provider CCN: 150175

Period:
From 10/01/2010
To 09/30/2011

Worksheet C
Part II
Date/Time Prepared:
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Cost Center Description		Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	
		6.00	7.00	8.00	
Title XIX Hospital PPS					
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	2,203,103	9,496,814	0.231983	50.00
54.00	RADIOLOGY-DIAGNOSTIC	613,917	4,257,198	0.144207	54.00
59.00	CARDIAC CATHETERIZATION	5,390,261	42,864,855	0.125750	59.00
60.00	LABORATORY	1,639,959	7,039,753	0.232957	60.00
64.00	INTRAVENOUS THERAPY	67,885	85,963	0.789700	64.00
65.00	RESPIRATORY THERAPY	378,325	1,109,504	0.340986	65.00
66.00	PHYSICAL THERAPY	49,313	494,302	0.099763	66.00
69.00	ELECTROCARDIOLOGY	330,697	5,718,909	0.057825	69.00
69.01	CARDIAC REHAB	420,259	966,708	0.434732	69.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,374,653	14,201,874	0.308034	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	9,964,592	15,190,743	0.655965	72.00
73.00	DRUGS CHARGED TO PATIENTS	2,234,903	9,887,327	0.226037	73.00
74.00	RENAL DIALYSIS	164,696	152,804	1.077825	74.00
76.00	OTHER ANCILLARY SERVICE COST CENTERS	3,250	4,181	0.777326	76.00
OUTPATIENT SERVICE COST CENTERS					
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	915,635	1,246,702	0.734446	92.00
200.00	Subtotal (sum of lines 50 thru 199)	28,751,448	0		200.00
201.00	Less Observation Beds	915,635	0		201.00
202.00	Total (line 200 minus line 201)	27,835,813	112,717,637		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 150175		Period: From 10/01/2010 To 09/30/2011		Worksheet D Part I Date/Time Prepared: 2/28/2012 3:03 pm	
Cost Center Description		Title XVIII		Hospital		PPS	
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	1,167,949	0	1,167,949	6,880	169.76	30.00
200.00	Total (lines 30-199)	1,167,949		1,167,949	6,880		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 150175		Period: From 10/01/2010 To 09/30/2011		Worksheet D Part I Date/Time Prepared: 2/28/2012 3:03 pm	
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	Title XVIII	Hospital	PPS	
		6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	3,194	542,213				30.00
200.00	Total (Lines 30-199)	3,194	542,213				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS			Provider CCN: 150175	Period: From 10/01/2010 To 09/30/2011	Worksheet D Part II Date/Time Prepared: 2/28/2012 3:03 pm		
Title XVIII			Hospital		PPS		
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	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	847,261	9,496,814	0.089215	5,036,578	449,338	50.00
54.00	RADIOLOGY-DIAGNOSTIC	1,022	4,257,198	0.000240	979,348	235	54.00
59.00	CARDIAC CATHETERIZATION	1,179,629	42,864,855	0.027520	6,733,290	185,300	59.00
60.00	LABORATORY	2,733	7,039,753	0.000388	3,567,930	1,384	60.00
64.00	INTRAVENOUS THERAPY	125	85,963	0.001454	55,636	81	64.00
65.00	RESPIRATORY THERAPY	631	1,109,504	0.000569	545,011	310	65.00
66.00	PHYSICAL THERAPY	82	494,302	0.000166	325,978	54	66.00
69.00	ELECTROCARDIOLOGY	41,558	5,718,909	0.007267	1,007,134	7,319	69.00
69.01	CARDIAC REHAB	54,303	966,708	0.056173	0	0	69.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,292	14,201,874	0.000513	4,971,633	2,550	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	16,612	15,190,743	0.001094	2,287,580	2,503	72.00
73.00	DRUGS CHARGED TO PATIENTS	3,724	9,887,327	0.000377	3,468,671	1,308	73.00
74.00	RENAL DIALYSIS	35,325	152,804	0.231179	117,549	27,175	74.00
76.00	OTHER ANCILLARY SERVICE COST CENTERS	5	4,181	0.001196	1,637	2	76.00
OUTPATIENT SERVICE COST CENTERS							
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	168,571	1,246,702	0.135214	163,877	22,158	92.00
200.00	Total (Lines 50-199)	2,358,873	112,717,637		29,261,852	699,717	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 150175		Period: From 10/01/2010 To 09/30/2011		Worksheet D Part III Date/Time Prepared: 2/28/2012 3:03 pm	
Cost Center Description		Title XVIII		Hospital		PPS	
		Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
200.00	Total (Lines 30-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 150175		Period: From 10/01/2010 To 09/30/2011		Worksheet D Part III Date/Time Prepared: 2/28/2012 3:03 pm	
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)	PPS	
		6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	6,880	0.00	3,194	0		30.00
200.00	Total (Lines 30-199)	6,880		3,194	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150175	Period: From 10/01/2010 To 09/30/2011	Worksheet D Part IV Date/Time Prepared: 2/28/2012 3:03 pm
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Cost Center Description	Title XVIII				Hospital	PPS	Total Cost (sum of col 1 through col. 4)	
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost				
	1.00	2.00	3.00	4.00		5.00		
ANCILLARY SERVICE COST CENTERS								
50.00 OPERATING ROOM	0	0	0	0	0	0	0	50.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	0	54.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	0	0	59.00
60.00 LABORATORY	0	0	0	0	0	0	0	60.00
64.00 INTRAVENOUS THERAPY	0	0	0	0	0	0	0	64.00
65.00 RESPIRATORY THERAPY	0	0	0	0	0	0	0	65.00
66.00 PHYSICAL THERAPY	0	0	0	0	0	0	0	66.00
69.00 ELECTROCARDIOLOGY	0	0	0	0	0	0	0	69.00
69.01 CARDIAC REHAB	0	0	0	0	0	0	0	69.01
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	0	73.00
74.00 RENAL DIALYSIS	0	0	0	0	0	0	0	74.00
76.00 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	0	92.00
200.00 Total (lines 50-199)	0	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150175	Period: From 10/01/2010 To 09/30/2011	Worksheet D Part IV Date/Time Prepared: 2/28/2012 3:03 pm
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Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	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	9,496,814	0.000000	0.000000	5,036,578	50.00
54.00	RADIOLOGY-DIAGNOSTIC	0	4,257,198	0.000000	0.000000	979,348	54.00
59.00	CARDIAC CATHETERIZATION	0	42,864,855	0.000000	0.000000	6,733,290	59.00
60.00	LABORATORY	0	7,039,753	0.000000	0.000000	3,567,930	60.00
64.00	INTRAVENOUS THERAPY	0	85,963	0.000000	0.000000	55,636	64.00
65.00	RESPIRATORY THERAPY	0	1,109,504	0.000000	0.000000	545,011	65.00
66.00	PHYSICAL THERAPY	0	494,302	0.000000	0.000000	325,978	66.00
69.00	ELECTROCARDIOLOGY	0	5,718,909	0.000000	0.000000	1,007,134	69.00
69.01	CARDIAC REHAB	0	966,708	0.000000	0.000000	0	69.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	14,201,874	0.000000	0.000000	4,971,633	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	15,190,743	0.000000	0.000000	2,287,580	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	9,887,327	0.000000	0.000000	3,468,671	73.00
74.00	RENAL DIALYSIS	0	152,804	0.000000	0.000000	117,549	74.00
76.00	OTHER ANCILLARY SERVICE COST CENTERS	0	4,181	0.000000	0.000000	1,637	76.00
OUTPATIENT SERVICE COST CENTERS							
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,246,702	0.000000	0.000000	163,877	92.00
200.00	Total (Lines 50-199)	0	112,717,637			29,261,852	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150175	Period: From 10/01/2010 To 09/30/2011	Worksheet D Part IV Date/Time Prepared: 2/28/2012 3:03 pm
		Title XVIII	Hospital
			PPS

Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS				
50.00 OPERATING ROOM	0	166,454	0	50.00
54.00 RADIOLOGY-DIAGNOSTIC	0	627,264	0	54.00
59.00 CARDIAC CATHETERIZATION	0	11,211,431	0	59.00
60.00 LABORATORY	0	9,603	0	60.00
64.00 INTRAVENOUS THERAPY	0	0	0	64.00
65.00 RESPIRATORY THERAPY	0	5,306	0	65.00
66.00 PHYSICAL THERAPY	0	0	0	66.00
69.00 ELECTROCARDIOLOGY	0	901,401	0	69.00
69.01 CARDIAC REHAB	0	425,759	0	69.01
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,587,348	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	5,080,574	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	795,115	0	73.00
74.00 RENAL DIALYSIS	0	2,723	0	74.00
76.00 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS				
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	289,344	0	92.00
200.00 Total (Lines 50-199)	0	22,102,322	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150175	Period: From 10/01/2010 To 09/30/2011	Worksheet D Part V Date/Time Prepared: 2/28/2012 3:03 pm
	Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges				
		PPS Reimbursed Services (see instructions)	Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)		
			1.00	2.00		
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0.231983	166,454	0	0		50.00
54.00 RADIOLOGY-DIAGNOSTIC	0.144207	627,264	0	0		54.00
59.00 CARDIAC CATHETERIZATION	0.125750	11,211,431	0	0		59.00
60.00 LABORATORY	0.232957	9,603	0	0		60.00
64.00 INTRAVENOUS THERAPY	0.789700	0	0	0		64.00
65.00 RESPIRATORY THERAPY	0.340986	5,306	0	0		65.00
66.00 PHYSICAL THERAPY	0.099763	0	0	0		66.00
69.00 ELECTROCARDIOLOGY	0.057825	901,401	0	0		69.00
69.01 CARDIAC REHAB	0.434732	425,759	0	0		69.01
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.308034	2,587,348	0	0		71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0.655965	5,080,574	0	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	0.226037	795,115	0	39,307		73.00
74.00 RENAL DIALYSIS	1.077825	2,723	0	0		74.00
76.00 OTHER ANCILLARY SERVICE COST CENTERS	0.777326	0	0	0		76.00
OUTPATIENT SERVICE COST CENTERS						
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0.734446	289,344	0	0		92.00
200.00 Subtotal (see instructions)		22,102,322	0	39,307		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00 Net Charges (line 200 +/- line 201)		22,102,322	0	39,307		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 150175		Period: From 10/01/2010 To 09/30/2011		Worksheet D Part V Date/Time Prepared: 2/28/2012 3:03 pm	
		Title XVIII		Hospital		PPS	
Cost Center Description	Costs						
	PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)				
	5.00	6.00	7.00				
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	38,614	0	0			50.00
54.00	RADIOLOGY-DIAGNOSTIC	90,456	0	0			54.00
59.00	CARDIAC CATHETERIZATION	1,409,837	0	0			59.00
60.00	LABORATORY	2,237	0	0			60.00
64.00	INTRAVENOUS THERAPY	0	0	0			64.00
65.00	RESPIRATORY THERAPY	1,809	0	0			65.00
66.00	PHYSICAL THERAPY	0	0	0			66.00
69.00	ELECTROCARDIOLOGY	52,124	0	0			69.00
69.01	CARDIAC REHAB	185,091	0	0			69.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	796,991	0	0			71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	3,332,679	0	0			72.00
73.00	DRUGS CHARGED TO PATIENTS	179,725	0	8,885			73.00
74.00	RENAL DIALYSIS	2,935	0	0			74.00
76.00	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0			76.00
OUTPATIENT SERVICE COST CENTERS							
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	212,508	0	0			92.00
200.00	Subtotal (see instructions)	6,305,006	0	8,885			200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges		0				201.00
202.00	Net Charges (line 200 +/- line 201)	6,305,006	0	8,885			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 150175		Period: From 10/01/2010 To 09/30/2011		Worksheet D Part I Date/Time Prepared: 2/28/2012 3:03 pm	
Cost Center Description		Title XIX		Hospital		PPS	
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	1,167,949	0	1,167,949	6,880	169.76	30.00
200.00	Total (lines 30-199)	1,167,949		1,167,949	6,880		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 150175		Period: From 10/01/2010 To 09/30/2011		Worksheet D Part I Date/Time Prepared: 2/28/2012 3:03 pm	
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	Title XIX	Hospital	PPS	
	INPATIENT ROUTINE SERVICE COST CENTERS	6.00	7.00				
30.00	ADULTS & PEDIATRICS	189	32,085				30.00
200.00	Total (Lines 30-199)	189	32,085				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS			Provider CCN: 150175	Period: From 10/01/2010 To 09/30/2011	Worksheet D Part II Date/Time Prepared: 2/28/2012 3:03 pm		
Title XIX			Hospital		PPS		
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	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	847,261	9,496,814	0.089215	197,126	17,587	50.00
54.00	RADIOLOGY-DIAGNOSTIC	1,022	4,257,198	0.000240	47,513	11	54.00
59.00	CARDIAC CATHETERIZATION	1,179,629	42,864,855	0.027520	471,986	12,989	59.00
60.00	LABORATORY	2,733	7,039,753	0.000388	178,393	69	60.00
64.00	INTRAVENOUS THERAPY	125	85,963	0.001454	0	0	64.00
65.00	RESPIRATORY THERAPY	631	1,109,504	0.000569	36,765	21	65.00
66.00	PHYSICAL THERAPY	82	494,302	0.000166	20,595	3	66.00
69.00	ELECTROCARDIOLOGY	41,558	5,718,909	0.007267	58,642	426	69.00
69.01	CARDIAC REHAB	54,303	966,708	0.056173	0	0	69.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,292	14,201,874	0.000513	192,924	99	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	16,612	15,190,743	0.001094	145,476	159	72.00
73.00	DRUGS CHARGED TO PATIENTS	3,724	9,887,327	0.000377	246,008	93	73.00
74.00	RENAL DIALYSIS	35,325	152,804	0.231179	0	0	74.00
76.00	OTHER ANCILLARY SERVICE COST CENTERS	5	4,181	0.001196	546	1	76.00
OUTPATIENT SERVICE COST CENTERS							
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	168,571	1,246,702	0.135214	0	0	92.00
200.00	Total (Lines 50-199)	2,358,873	112,717,637		1,595,974	31,458	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 150175		Period: From 10/01/2010 To 09/30/2011		Worksheet D Part III Date/Time Prepared: 2/28/2012 3:03 pm	
Cost Center Description		Title XIX		Hospital		PPS	
		Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
200.00	Total (Lines 30-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 150175		Period: From 10/01/2010 To 09/30/2011		Worksheet D Part III Date/Time Prepared: 2/28/2012 3:03 pm	
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)	PPS	
		6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	6,880	0.00	189	0	30.00	
200.00	Total (Lines 30-199)	6,880		189	0	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150175	Period: From 10/01/2010 To 09/30/2011	Worksheet D Part IV Date/Time Prepared: 2/28/2012 3:03 pm
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Cost Center Description	Title XIX				Hospital	PPS	Total Cost (sum of col 1 through col. 4)	
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost				
	1.00	2.00	3.00	4.00		5.00		
ANCILLARY SERVICE COST CENTERS								
50.00 OPERATING ROOM	0	0	0	0	0	0	0	50.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	0	54.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	0	0	59.00
60.00 LABORATORY	0	0	0	0	0	0	0	60.00
64.00 INTRAVENOUS THERAPY	0	0	0	0	0	0	0	64.00
65.00 RESPIRATORY THERAPY	0	0	0	0	0	0	0	65.00
66.00 PHYSICAL THERAPY	0	0	0	0	0	0	0	66.00
69.00 ELECTROCARDIOLOGY	0	0	0	0	0	0	0	69.00
69.01 CARDIAC REHAB	0	0	0	0	0	0	0	69.01
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	0	73.00
74.00 RENAL DIALYSIS	0	0	0	0	0	0	0	74.00
76.00 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	0	92.00
200.00 Total (lines 50-199)	0	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150175	Period: From 10/01/2010 To 09/30/2011	Worksheet D Part IV Date/Time Prepared: 2/28/2012 3:03 pm
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Cost Center Description	Title XIX			Hospital		Inpatient Program Charges	
	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)	PPS		
	6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS							
50.00 OPERATING ROOM	0	9,496,814	0.000000	0.000000	197,126	50.00	
54.00 RADIOLOGY-DIAGNOSTIC	0	4,257,198	0.000000	0.000000	47,513	54.00	
59.00 CARDIAC CATHETERIZATION	0	42,864,855	0.000000	0.000000	471,986	59.00	
60.00 LABORATORY	0	7,039,753	0.000000	0.000000	178,393	60.00	
64.00 INTRAVENOUS THERAPY	0	85,963	0.000000	0.000000	0	64.00	
65.00 RESPIRATORY THERAPY	0	1,109,504	0.000000	0.000000	36,765	65.00	
66.00 PHYSICAL THERAPY	0	494,302	0.000000	0.000000	20,595	66.00	
69.00 ELECTROCARDIOLOGY	0	5,718,909	0.000000	0.000000	58,642	69.00	
69.01 CARDIAC REHAB	0	966,708	0.000000	0.000000	0	69.01	
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	14,201,874	0.000000	0.000000	192,924	71.00	
72.00 IMPL. DEV. CHARGED TO PATIENT	0	15,190,743	0.000000	0.000000	145,476	72.00	
73.00 DRUGS CHARGED TO PATIENTS	0	9,887,327	0.000000	0.000000	246,008	73.00	
74.00 RENAL DIALYSIS	0	152,804	0.000000	0.000000	0	74.00	
76.00 OTHER ANCILLARY SERVICE COST CENTERS	0	4,181	0.000000	0.000000	546	76.00	
OUTPATIENT SERVICE COST CENTERS							
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	1,246,702	0.000000	0.000000	0	92.00	
200.00 Total (Lines 50-199)	0	112,717,637			1,595,974	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150175

Period:
From 10/01/2010
To 09/30/2011

Worksheet D
Part IV
Date/Time Prepared:
2/28/2012 3:03 pm

Cost Center Description		Title XIX			Hospital	PPS
		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	11,546	0		50.00
54.00	RADIOLOGY-DIAGNOSTIC	0	68,814	0		54.00
59.00	CARDIAC CATHETERIZATION	0	778,414	0		59.00
60.00	LABORATORY	0	60,094	0		60.00
64.00	INTRAVENOUS THERAPY	0	0	0		64.00
65.00	RESPIRATORY THERAPY	0	543	0		65.00
66.00	PHYSICAL THERAPY	0	0	0		66.00
69.00	ELECTROCARDIOLOGY	0	113,209	0		69.00
69.01	CARDIAC REHAB	0	16,573	0		69.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	187,657	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0	378,287	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	70,714	0		73.00
74.00	RENAL DIALYSIS	0	0	0		74.00
76.00	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0		76.00
OUTPATIENT SERVICE COST CENTERS						
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	50,511	0		92.00
200.00	Total (Lines 50-199)	0	1,736,362	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150175	Period: From 10/01/2010 To 09/30/2011	Worksheet D Part V Date/Time Prepared: 2/28/2012 3:03 pm
	Title XIX	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges				
		PPS Reimbursed Services (see instructions)	Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)		
			1.00	2.00		
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0.231983	11,546	0	0		50.00
54.00 RADIOLOGY-DIAGNOSTIC	0.144207	68,814	0	0		54.00
59.00 CARDIAC CATHETERIZATION	0.125750	778,414	0	0		59.00
60.00 LABORATORY	0.232957	60,094	0	0		60.00
64.00 INTRAVENOUS THERAPY	0.789700	0	0	0		64.00
65.00 RESPIRATORY THERAPY	0.340986	543	0	0		65.00
66.00 PHYSICAL THERAPY	0.099763	0	0	0		66.00
69.00 ELECTROCARDIOLOGY	0.057825	113,209	0	0		69.00
69.01 CARDIAC REHAB	0.434732	16,573	0	0		69.01
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.308034	187,657	0	0		71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0.655965	378,287	0	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	0.226037	70,714	0	0		73.00
74.00 RENAL DIALYSIS	1.077825	0	0	0		74.00
76.00 OTHER ANCILLARY SERVICE COST CENTERS	0.777326	0	0	0		76.00
OUTPATIENT SERVICE COST CENTERS						
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0.734446	50,511	0	0		92.00
200.00 Subtotal (see instructions)		1,736,362	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)		1,736,362	0	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150175	Period: From 10/01/2010 To 09/30/2011	Worksheet D Part V Date/Time Prepared: 2/28/2012 3:03 pm
Title XIX		Hospital	PPS

Cost Center Description	Costs				
	PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)		
	5.00	6.00	7.00		
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	2,678	0	0		50.00
54.00 RADIOLOGY-DIAGNOSTIC	9,923	0	0		54.00
59.00 CARDIAC CATHETERIZATION	97,886	0	0		59.00
60.00 LABORATORY	13,999	0	0		60.00
64.00 INTRAVENOUS THERAPY	0	0	0		64.00
65.00 RESPIRATORY THERAPY	185	0	0		65.00
66.00 PHYSICAL THERAPY	0	0	0		66.00
69.00 ELECTROCARDIOLOGY	6,546	0	0		69.00
69.01 CARDIAC REHAB	7,205	0	0		69.01
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	57,805	0	0		71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	248,143	0	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	15,984	0	0		73.00
74.00 RENAL DIALYSIS	0	0	0		74.00
76.00 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0		76.00
OUTPATIENT SERVICE COST CENTERS					
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	37,098	0	0		92.00
200.00 Subtotal (see instructions)	497,452	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)	497,452	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150175	Period: From 10/01/2010 To 09/30/2011	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 2/28/2012 3:03 pm
Cost Center Description				PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		6,880	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		6,880	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)		6,880	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		3,194	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)		6,344,004	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		6,344,004	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		10,008,105	28.00
29.00	Private room charges (excluding swing-bed charges)		10,008,105	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.633887	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		6,344,004	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)		922.09	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,945,155	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		2,945,155	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 150175	Period: From 10/01/2010 To 09/30/2011	Worksheet D-1 Date/Time Prepared: 2/28/2012 3:03 pm
Title XVIII			Hospital	PPS	
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)					7,372,802 48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					10,317,957 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)					542,213 50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					699,717 51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					1,241,930 52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					9,076,027 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)					993 87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					922.09 88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					915,635 89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150175		Period: From 10/01/2010 To 09/30/2011		Worksheet D-1 Date/Time Prepared: 2/28/2012 3:03 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,167,949	6,344,004	0.184103	915,635	168,571	90.00
91.00	Nursing School cost	0	6,344,004	0.000000	915,635	0	91.00
92.00	Allied health cost	0	6,344,004	0.000000	915,635	0	92.00
93.00	All other Medical Education	0	6,344,004	0.000000	915,635	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150175	Period: From 10/01/2010 To 09/30/2011	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 2/28/2012 3:03 pm
Cost Center Description				PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		6,880	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		6,880	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)		6,880	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		189	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)		6,344,004	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		6,344,004	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		6,344,004	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)		922.09	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		174,275	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)		174,275	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 150175	Period: From 10/01/2010 To 09/30/2011	Worksheet D-1 Date/Time Prepared: 2/28/2012 3:03 pm
Cost Center Description			Title XIX	Hospital	PPS
	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)				382,359 48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				556,634 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)				32,085 50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				31,458 51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)				63,543 52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				493,091 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)				993 87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				922.09 88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				915,635 89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150175		Period: From 10/01/2010 To 09/30/2011		Worksheet D-1 Date/Time Prepared: 2/28/2012 3:03 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,167,949	6,344,004	0.184103	915,635	168,571	90.00
91.00	Nursing School cost	0	6,344,004	0.000000	915,635	0	91.00
92.00	Allied health cost	0	6,344,004	0.000000	915,635	0	92.00
93.00	All other Medical Education	0	6,344,004	0.000000	915,635	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150175	Period: From 10/01/2010 To 09/30/2011	Worksheet D-3 Date/Time Prepared: 2/28/2012 3:03 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS		4,642,845		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.231983	5,036,578	1,168,400	50.00
54.00	RADIOLOGY-DIAGNOSTIC	0.144207	979,348	141,229	54.00
59.00	CARDIAC CATHETERIZATION	0.125750	6,733,290	846,711	59.00
60.00	LABORATORY	0.232957	3,567,930	831,174	60.00
64.00	INTRAVENOUS THERAPY	0.789700	55,636	43,936	64.00
65.00	RESPIRATORY THERAPY	0.340986	545,011	185,841	65.00
66.00	PHYSICAL THERAPY	0.099763	325,978	32,521	66.00
69.00	ELECTROCARDIOLOGY	0.057825	1,007,134	58,238	69.00
69.01	CARDIAC REHAB	0.434732	0	0	69.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.308034	4,971,633	1,531,432	71.00
72.00	IMPL. DEV. CHARGED TO PATIENT	0.655965	2,287,580	1,500,572	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.226037	3,468,671	784,048	73.00
74.00	RENAL DIALYSIS	1.080986	117,549	127,069	74.00
76.00	OTHER ANCILLARY SERVICE COST CENTERS	0.777326	1,637	1,272	76.00
OUTPATIENT SERVICE COST CENTERS					
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.734446	163,877	120,359	92.00
200.00	Total (sum of lines 50-94 and 96-98)		29,261,852	7,372,802	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)		29,261,852		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150175	Period: From 10/01/2010 To 09/30/2011	Worksheet D-3 Date/Time Prepared: 2/28/2012 3:03 pm
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Cost Center Description	Title XIX		Hospital		PPS
	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		333,282			30.00
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	0.231983	197,126	45,730		50.00
54.00 RADIOLOGY-DIAGNOSTIC	0.144207	47,513	6,852		54.00
59.00 CARDIAC CATHETERIZATION	0.125750	471,986	59,352		59.00
60.00 LABORATORY	0.232957	178,393	41,558		60.00
64.00 INTRAVENOUS THERAPY	0.789700	0	0		64.00
65.00 RESPIRATORY THERAPY	0.340986	36,765	12,536		65.00
66.00 PHYSICAL THERAPY	0.099763	20,595	2,055		66.00
69.00 ELECTROCARDIOLOGY	0.057825	58,642	3,391		69.00
69.01 CARDIAC REHAB	0.434732	0	0		69.01
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.308034	192,924	59,427		71.00
72.00 IMPL. DEV. CHARGED TO PATIENT	0.655965	145,476	95,427		72.00
73.00 DRUGS CHARGED TO PATIENTS	0.226037	246,008	55,607		73.00
74.00 RENAL DIALYSIS	1.080986	0	0		74.00
76.00 OTHER ANCILLARY SERVICE COST CENTERS	0.777326	546	424		76.00
OUTPATIENT SERVICE COST CENTERS					
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0.734446	0	0		92.00
200.00 Total (sum of lines 50-94 and 96-98)		1,595,974	382,359		200.00
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0		201.00
202.00 Net Charges (line 200 minus line 201)		1,595,974			202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150175	Period: From 10/01/2010 To 09/30/2011	Worksheet E Part A Date/Time Prepared: 2/28/2012 3:03 pm
		Title XVIII	Hospital	PPS
			before 1/1	on/after 1/1
			1.00	1.01
PART A - INPATIENT HOSPITAL SERVICES UNDER PPS				
1.00	DRG Amounts Other than Outlier Payments		8,498,619	1.00
2.00	Outlier payments for discharges. (see instructions)		132,837	2.00
3.00	Managed Care Simulated Payments		0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		21.28	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 Federal Register, page 50069, August 1, 2002.		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment. (see instructions)		0.000000	27.00
28.00	IME Adjustment (see instructions)		0	28.00
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		0.00	30.00
31.00	Percentage of Medicaid patient days to total days reported on Worksheet S-2, Part I, line 24. (see instructions)		0.00	31.00
32.00	Sum of lines 30 and 31		0.00	32.00
33.00	Allowable disproportionate share percentage (see instructions)		0.00	33.00
34.00	Disproportionate share adjustment (see instructions)		0	34.00
Additional payment for high percentage of ESRD beneficiary discharges				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0	40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	41.00
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00	42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000	44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41)		0	46.00
47.00	Subtotal (see instructions)		8,631,456	47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0	48.00
49.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)		8,631,456	49.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150175	Period: From 10/01/2010 To 09/30/2011	Worksheet E Part A Date/Time Prepared: 2/28/2012 3:03 pm
		Title XVIII	Hospital	PPS
		before 1/1	on/after 1/1	
		1.00	1.01	
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)	736,379		50.00
51.00	Exception payment for inpatient program capital (Worksheet L, Part III, see instructions)	0		51.00
52.00	Direct graduate medical education payment (from Worksheet E-4, line 49 see instructions).	0		52.00
53.00	Nursing and Allied Health Managed Care payment	0		53.00
54.00	Special add-on payments for new technologies	0		54.00
55.00	Net organ acquisition cost (Worksheet D-4 Part III, col. 1, line 69)	0		55.00
56.00	Cost of teaching physicians (Worksheet D-5, Part II, col. 3, line 20)	0		56.00
57.00	Routine service other pass through costs	0		57.00
58.00	Ancillary service other pass through costs Worksheet D, Part IV, col. 11 line 200)	0		58.00
59.00	Total (sum of amounts on lines 49 through 58)	9,367,835		59.00
60.00	Primary payer payments	2,687		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	9,365,148		61.00
62.00	Deductibles billed to program beneficiaries	707,912		62.00
63.00	Coinsurance billed to program beneficiaries	0		63.00
64.00	Allowable bad debts (see instructions)	45,257		64.00
65.00	Adjusted reimbursable bad debts (see instructions)	31,680		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	29,800		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	8,688,916		67.00
68.00	Credits received from manufacturers for replaced devices applicable to MS-DRG (see instructions)	0		68.00
69.00	Outlier payments reconciliation	0		69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0		70.00
70.95	Recovery of Accelerated Depreciation	0		70.95
70.96	Low Volume Payment-1	0		70.96
70.97	Low Volume Payment-2	0		70.97
70.98	Low Volume Payment-3	0		70.98
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)	8,688,916		71.00
72.00	Interim payments	8,657,236		72.00
73.00	Tentative settlement (for contractor use only)	0		73.00
74.00	Balance due provider (Program) (line 71 minus the sum of lines 72 and 73)	31,680		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0		75.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Operating outlier amount from Worksheet E, Part A line 2	0		90.00
91.00	Capital outlier from Worksheet L, Part I, line 2	0		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)	0		92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)	0		93.00
94.00	The rate used to calculate the Time Value of Money	0.00		94.00
95.00	Time Value of Money for operating expenses(see instructions)	0		95.00
96.00	Time Value of Money for capital related expenses (see instructions)	0		96.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150175	Period: From 10/01/2010 To 09/30/2011	Worksheet E Part B Date/Time Prepared: 2/28/2012 3:03 pm
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		8,885	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		6,305,006	2.00
3.00	PPS payments		6,470,950	3.00
4.00	Outlier payment (see instructions)		119,175	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)		8,885	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		39,307	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)		39,307	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		39,307	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		30,422	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)		8,885	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)		6,590,125	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		914,485	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)		5,684,525	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)		5,684,525	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		5,684,525	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)		66,610	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		46,627	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		47,180	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)		5,731,152	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)		5,731,152	40.00
41.00	Interim payments		5,677,503	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)		53,649	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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 150175

Period:
From 10/01/2010
To 09/30/2011

Worksheet E-1
Part I
Date/Time Prepared:
2/28/2012 3:03 pm

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		8,657,236		5,677,503	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		8,657,236		5,677,503	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		31,680		53,649	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		8,688,916		5,731,152	7.00	
				Contractor Number	Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor						8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 150175	Period: From 10/01/2010 To 09/30/2011	Worksheet E-1 Part II Date/Time Prepared: 2/28/2012 3:03 pm
		Title XVIII	Hospital	PPS
				1.00
DATA COLLECTION NEEDED FOR THE HIT CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14			1,630 1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12			3,194 2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6. line 2			694 3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12			5,887 4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200			122,725,742 5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20			2,217,994 6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168			0 7.00
8.00	Calculation of the HIT incentive payment (see instructions)			1,409,795 8.00
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH				
30.00	Initial/interim HIT payment(s)			0 30.00
31.00	Other Adjustment (specify)			0 31.00
32.00	Balance due provider (line 8 minus line 30, plus or minus line 31)			1,409,795 32.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

Provider CCN: 150175

Period:
From 10/01/2010
To 09/30/2011

Worksheet G

Date/Time Prepared:
2/28/2012 3:03 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	5,756,963	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	17,941,818	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-10,923,008	0	0	0	6.00
7.00	Inventory	791,207	0	0	0	7.00
8.00	Prepaid expenses	45,781	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	13,612,761	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	0	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	5,274,221	0	0	0	19.00
20.00	Accumulated depreciation	-2,322,042	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	2,952,179	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	6,658,815	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	6,658,815	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	23,223,755	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	790,900	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,131	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	6,907,833	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	7,699,864	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	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	7,699,864	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	15,523,891				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)	15,523,891	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	23,223,755	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 150175

Period:
From 10/01/2010
To 09/30/2011

Worksheet G-1

Date/Time Prepared:
2/28/2012 3:03 pm

		General Fund		Special Purpose Fund		
		1.00	2.00	3.00	4.00	
1.00	Fund balances at beginning of period		12,842,397		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		8,301,290			2.00
3.00	Total (sum of line 1 and line 2)		21,143,687		0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		0		0	10.00
11.00	Subtotal (line 3 plus line 10)		21,143,687		0	11.00
12.00	DISTRIBUTIONS TO MEMBERS	5,619,796		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)		5,619,796		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		15,523,891		0	19.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 150175

Period:
From 10/01/2010
To 09/30/2011

Worksheet G-1

Date/Time Prepared:
2/28/2012 3:03 pm

	Endowment Fund		Plant Fund			
	5.00	6.00	7.00	8.00		
1.00						1.00
		0			0	
2.00						2.00
3.00		0			0	3.00
4.00	0		0			4.00
	0		0			
5.00	0		0			5.00
	0		0			
6.00	0		0			6.00
	0		0			
7.00	0		0			7.00
	0		0			
8.00	0		0			8.00
	0		0			
9.00	0		0			9.00
		0			0	
10.00						10.00
		0			0	
11.00						11.00
	0		0			
12.00	0		0			12.00
	0		0			
13.00	0		0			13.00
	0		0			
14.00	0		0			14.00
	0		0			
15.00	0		0			15.00
	0		0			
16.00	0		0			16.00
	0		0			
17.00	0		0			17.00
		0			0	
18.00						18.00
		0			0	
19.00						19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 150175

Period:
From 10/01/2010
To 09/30/2011

Worksheet G-2 Parts

Date/Time Prepared:
2/28/2012 3:03 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	10,395,960		10,395,960	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	10,395,960		10,395,960	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	10,395,960		10,395,960	17.00
18.00	Ancillary services	58,226,240	56,607,208	114,833,448	18.00
19.00	Outpatient services	0	977,611	977,611	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	68,622,200	57,584,819	126,207,019	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		36,646,814		29.00
30.00	BAD DEBT	1,910,757			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		1,910,757		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		38,557,571		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 150175

Period:
From 10/01/2010
To 09/30/2011

Worksheet G-3

Date/Time Prepared:
2/28/2012 3:03 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	126,207,019	1.00
2.00	Less contractual allowances and discounts on patients' accounts	79,349,366	2.00
3.00	Net patient revenues (line 1 minus line 2)	46,857,653	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	38,557,571	4.00
5.00	Net income from service to patients (line 3 minus line 4)	8,300,082	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and telegraph service	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING REVENUE	1,206	24.00
25.00	Total other income (sum of lines 6-24)	1,206	25.00
26.00	Total (line 5 plus line 25)	8,301,288	26.00
27.00	ROUNDING VARIANCE	-2	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	-2	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	8,301,290	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 150175	Period: From 10/01/2010 To 09/30/2011	Worksheet L Parts I-III Date/Time Prepared: 2/28/2012 3:03 pm
		Title XVIII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		680,603	1.00
2.00	Capital DRG outlier payments		55,776	2.00
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		16.24	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (line 1 times line 5)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days reported on Worksheet S-3, Part I (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (line 1 times line 10)		0	11.00
12.00	Total prospective capital payments (sum of lines 1-2, 6, and 11)		736,379	12.00
				1.00
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
				1.00
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00