

**ST. MARY'S WARRICK HOSPITAL  
BOONEVILLE, INDIANA**

**PROVIDER NOS. 15-1325, 15-M325, 15-Z325  
AND AIM NO. 100270700**

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

**JUNE 30, 2011**

**ST. MARY'S WARRICK HOSPITAL**

**PROVIDER NOS. 15-1325, 15-M325, 15-Z325  
AND AIM NO. 100270700**

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**Accounts' Disclaimer**

**Hospital Statements of Reimbursable Costs**



Board of Directors  
St. Mary's Warrick Hospital  
Boonville, Indiana

We have compiled the Hospital Statements of Reimbursable Costs (Title XVIII and XIX) of St. Mary's Warrick Hospital for the year ended June 30, 2011 in the accompanying prescribed form in accordance with Statements on Standards for Accounting Review Services issued by the American Institute of Certified Public Accountants.

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

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

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

*Bradley Associates*

January 27, 2012

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 151325	Period: From 07/01/2010 To 06/30/2011	worksheet 5 Parts I-III Date/Time Prepared: 1/27/2012 11:30 am
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**PART I - COST REPORT STATUS**

Provider use only	1. <input type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 1/27/2012 Time: 11:30 am
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

**PART II - CERTIFICATION**

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST. MARY'S WARRICK HOSPITAL, INC. for the cost reporting period beginning 07/01/2010 and ending 06/30/2011 and to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services identified in this cost report were provided in compliance with such laws and regulations.

Encryption Information

ECR: Date: 1/27/2012 Time: 11:30 am  
Qx1MKAWQrGwOFa59US:HI61LQYm00  
nStva0N:5jgicphwKzim.Gejou4uzk  
8zC80QHU3v0FnLF3  
PI: Date: 1/27/2012 Time: 11:30 am  
H8ARWEBNYDCE1xwKkImEvhk19uV1.0  
basPE0upDypBYBmsw1sTw5Hm2NE0m  
IfCoUXtnV5049wly

(Signed)

\_\_\_\_\_  
Officer or Administrator of Provider(s)

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

	Title v 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	-55,216	215,211	0	0	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
4.00 SUBPROVIDER I	0	0	0	0	0	4.00
5.00 Swing bed - SNF	0	51,855	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
7.00 Skilled Nursing Facility	0	0	0	0	0	7.00
8.00 Nursing Facility	0	0	0	0	0	8.00
9.00 HOME HEALTH AGENCY I	0	0	0	0	0	9.00
10.00 RURAL HEALTH CLINIC I	0	0	0	0	0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0	0	0	0	0	11.00
12.00 CMHC I	0	0	0	0	0	12.00
200.00 Total	0	-3,361	215,211	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151325		Period: From 07/01/2010 To 06/30/2011		Worksheet S-2 Part I Date/Time Prepared: 1/26/2012 12:42 pm							
1.00		2.00		3.00		4.00							
<b>Hospital and Hospital Health Care Complex Address:</b>													
1.00	Street: 1116 MILLIS AVE		PO Box:				1.00						
2.00	City: BOONEVILLE		State: IN		Zip Code: 47601		County: WARRICK						
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)					
				1.00	2.00	3.00	4.00	5.00					
								V XVIII XIX					
								6.00 7.00 8.00					
<b>Hospital and Hospital-Based Component Identification:</b>													
3.00	Hospital		ST. MARY'S WARRICK HOSPITAL, INC.		151325	21780	1	03/01/2005	N	O	O	3.00	
4.00	Subprovider - IPF		SERENITY PSYCH UNIT		15M325	21780	4	03/01/2005	N	P	O	4.00	
5.00	Subprovider - IRF											5.00	
6.00	Subprovider - (Other)											6.00	
7.00	Swing Beds - SNF		ST. MARY'S WARRICK - SWING BED		15Z325	21780		03/01/2005	N	O	N	7.00	
8.00	Swing Beds - NF								N		N	8.00	
9.00	Hospital-Based SNF											9.00	
10.00	Hospital-Based NF											10.00	
11.00	Hospital-Based OLTC											11.00	
12.00	Hospital-Based HHA											12.00	
13.00	Separately Certified ASC											13.00	
14.00	Hospital-Based Hospice											14.00	
15.00	Hospital-Based Health Clinic - RHC											15.00	
16.00	Hospital-Based Health Clinic - FQHC											16.00	
17.00	Hospital-Based (CMHC) 1											17.00	
18.00	Renal Dialysis											18.00	
19.00	Other											19.00	
							From:		To:				
							1.00		2.00				
20.00	Cost Reporting Period (mm/dd/yyyy)						07/01/2010		06/30/2011		20.00		
21.00	Type of Control (see instructions)								1		21.00		
<b>Inpatient PPS Information</b>													
22.00	Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.						N		N		22.00		
23.00	Indicate in column 1 the method used to capture Medicaid (title XIX) days reported on lines 24 and/or 25 of this worksheet during the cost reporting period by entering a "1" if days are based on the date of admission, "2" if days are based on census days (also referred to as the day count), or "3" if the days are based on the date of discharge. Is the method of identifying the days in the current cost reporting period different from the method used in the prior cost reporting period? Enter in column 2 "Y" for yes or "N" for no.								2		N		23.00
				In-State Medicaid paid days	In-State Medicaid eligible days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible days	Medicaid HMO days	Other Medicaid days				
				1.00	2.00	3.00	4.00	5.00	6.00				
24.00	If line 22 and/or line 45 is "yes", and this provider is an IPPS hospital enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible days in col. 4, Medicaid HMO days in col. 5, and other Medicaid days in col. 6.			0	0	0	0	0	0		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		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151325	Period: From 07/01/2010 To 06/30/2011	Worksheet S-2 Part I Date/Time Prepared: 1/26/2012 12:42 pm		
		Beginning: 1.00	Ending: 2.00			
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0				37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.					38.00
		V 1.00	XVIII 2.00	XIX 3.00		
<b>Prospective Payment System (PPS)-Capital</b>						
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
<b>Teaching Hospitals</b>						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N				56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete worksheet E-4. If column 2 is "N", complete worksheet D, Part III & IV and D-2, Part II, if applicable.					57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete worksheet D-5.					58.00
59.00	Are costs claimed on line 100 of worksheet A? If yes, complete worksheet D-2, Part I.	N				59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N				60.00
		Y/N 1.00	IME Average 2.00	Direct GME Average 3.00		
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)	N	0.00		0.00	61.00
<b>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</b>						
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
<b>Teaching Hospitals that Claim Residents in Non-Provider Settings</b>						
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete lines 64-67. (see instructions)	N				63.00
		Unweighted FTEs Nonprovider Site 1.00	Unweighted FTEs in Hospital 2.00	Ratio (col. 1/(col. 1 + col. 2)) 3.00		
<b>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.</b>						
64.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	64.00
		Program Name 1.00	Program Code 2.00	Unweighted FTEs Nonprovider Site 3.00	Unweighted FTEs in Hospital 4.00	Ratio (col. 3/(col. 3 + col. 4)) 5.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 151325

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

Worksheet S-2  
Part I  
Date/Time Prepared:  
1/26/2012 12:42 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151325	Period: From 07/01/2010 To 06/30/2011	Worksheet S-2 Part I Date/Time Prepared: 1/26/2012 12:42 pm
			1.00	
<b>TEFRA Providers</b>				
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 1.00	XIX 2.00
<b>Title V or XIX Inpatient Services</b>				
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	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	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	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
<b>Rural Providers</b>				
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?		Y	105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)		N	106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)		N	N 107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		N	108.00
			Physical 1.00	Occupational 2.00
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	N 109.00
			Speech 3.00	Respiratory 4.00
			1.00	2.00
<b>Miscellaneous Cost Reporting Information</b>				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2.		N	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.		N	116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.		Y	117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.			2 118.00
119.00	What is the liability limit for the malpractice insurance policy? Enter in column 1 the monetary limit per lawsuit. Enter in column 2 the monetary limit per policy year.			1 119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 as amended by the Medicaid Extender Act (MMEA) §108? Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with <= 100 beds that qualifies for the outpatient Hold Harmless provision in ACA §3121? Enter in column 2 "Y" for yes or "N" for no.		N	N 120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.		Y	121.00
<b>Transplant Center Information</b>				
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

1/26/2012 12:42 pm X:\HFSdata\clients\Hospital\St Marys Warrick\2622-11.mcrx

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151325		Period: From 07/01/2010 To 06/30/2011		Worksheet S-2 Part I Date/Time Prepared: 1/26/2012 12:42 pm	
		1.00		2.00			
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.						134.00
<b>All Providers</b>							
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		158056			140.00
		1.00	2.00	3.00			
<b>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.</b>							
141.00	Name: ST. MARY'S HEALTH SYSTEM	Contractor's Name: NGS		Contractor's Number: 15H056			141.00
142.00	Street: 3700 WASHINGTON AVE.	PO Box:					142.00
143.00	City: EVANSVILLE	State: IN		Zip Code: 47550			143.00
						1.00	
144.00	Are provider based physicians' costs included in worksheet A?			Y			144.00
145.00	If costs for renal services are claimed on worksheet A, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.			N			145.00
						1.00	
						2.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N					146.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N					147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N					148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N					149.00
						Part A	Part B
						1.00	2.00
<b>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)</b>							
155.00	Hospital	N		N			155.00
156.00	Subprovider - IPF	N		N			156.00
157.00	Subprovider - IRF	N		N			157.00
158.00	Subprovider - Other	N		N			158.00
159.00	SNF	N		N			159.00
160.00	HHA	N		N			160.00
161.00	CMHC	N		N			161.00
							1.00
<b>Multicampus</b>							
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.					N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus
		0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00
							1.00
<b>Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act</b>							
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.					N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						0.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 151325	Period: From 07/01/2010 To 06/30/2011	Worksheet S-2 Part II Date/Time Prepared: 1/26/2012 12:43 pm
		Y/N	Date	
		1.00	2.00	
<b>General Instruction:</b> Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
<b>COMPLETED BY ALL HOSPITALS</b>				
<b>Provider Organization and Operation</b>				
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
<b>Financial Data and Reports</b>				
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	09/15/2011
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
		Y/N	Legal Oper.	
		1.00	2.00	
<b>Approved Educational Activities</b>				
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		
<b>Bad Debts</b>				
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
<b>Bed Complement</b>				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N	15.00
		Description	Part A	
		0	Y/N Date	
			1.00 2.00	
<b>PS&amp;R Data</b>				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	12/01/2011	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 151325	Period: From 07/01/2010 To 06/30/2011	Worksheet S-2 Part II Date/Time Prepared: 1/26/2012 12:43 pm
	Description	Part A		
		Y/N	Date	
	0	1.00	2.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		21.00
				1.00
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>				
<b>Capital Related Cost</b>				
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N		27.00
<b>Interest Expense</b>				
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	Y		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N		31.00
<b>Purchased Services</b>				
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N		33.00
<b>Provider-Based Physicians</b>				
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	N		35.00
				Y/N
				Date
				1.00
				2.00
<b>Home Office Costs</b>				
36.00	Were home office costs claimed on the cost report?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 151325

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

Worksheet S-2  
Part II  
Date/Time Prepared:  
1/26/2012 12:43 pm

		Part B		
		Y/N	Date	
		3.00	4.00	
<b>PS&amp;R Data</b>				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	12/01/2011	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		21.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151325

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
1/26/2012 12:42 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	25	9,125	51,408.00	1.00
2.00 HMO					2.00
3.00 HMO IPF					3.00
4.00 HMO IRF					4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					5.00
6.00 Hospital Adults & Peds. Swing Bed NF					6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	51,408.00	7.00
8.00 INTENSIVE CARE UNIT	31.00	0	0	0.00	8.00
9.00 CORONARY CARE UNIT					9.00
10.00 BURN INTENSIVE CARE UNIT					10.00
11.00 SURGICAL INTENSIVE CARE UNIT					11.00
12.00 OTHER SPECIAL CARE (SPECIFY)					12.00
13.00 NURSERY					13.00
14.00 Total (see instructions)		25	9,125	51,408.00	14.00
15.00 CAH visits					15.00
16.00 SUBPROVIDER - IPF	40.00	10	3,650		16.00
17.00 SUBPROVIDER - IRF	41.00	0	0		17.00
18.00 SUBPROVIDER	42.00	0	0		18.00
19.00 SKILLED NURSING FACILITY					19.00
20.00 NURSING FACILITY					20.00
21.00 OTHER LONG TERM CARE					21.00
22.00 HOME HEALTH AGENCY					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)		35			27.00
28.00 Observation Bed Days					28.00
28.01 SUBPROVIDER - IPF	40.00				28.01
28.02 SUBPROVIDER - IRF	41.00				28.02
28.03 SUBPROVIDER	42.00				28.03
29.00 Ambulance Trips					29.00
30.00 Employee discount days (see instruction)					30.00
31.00 Employee discount days - IRF					31.00
32.00 Labor & delivery days (see instructions)					32.00
33.00 LTCH non-covered days					33.00

Cost Center Description	I/P Days / O/P Visits / Trips					
	Title v	Title XVIII	Title XIX	Total All Patients		
	5.00	6.00	7.00	8.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, observation Bed and Hospice days)	0	1,277	237	2,142		1.00
2.00 HMO		0	0			2.00
3.00 HMO IPF		0	0			3.00
4.00 HMO IRF		0	0			4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	1,371	0	1,371		5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0		0	693		6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	0	2,648	237	4,206		7.00
8.00 INTENSIVE CARE UNIT	0	0	0	0		8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0	2,648	237	4,206		14.00
15.00 CAH visits	0	0	0	0		15.00
16.00 SUBPROVIDER - IPF	0	2,865	0	3,388		16.00
17.00 SUBPROVIDER - IRF	0	0	0	0		17.00
18.00 SUBPROVIDER	0	0	0	0		18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)						27.00
28.00 Observation Bed Days	0		0	849		28.00
28.01 SUBPROVIDER - IPF	0	0	0	0		28.01
28.02 SUBPROVIDER - IRF	0	0	0	0		28.02
28.03 SUBPROVIDER	0	0	0	0		28.03
29.00 Ambulance Trips		0				29.00
30.00 Employee discount days (see instruction)				0		30.00
31.00 Employee discount days - IRF				0		31.00
32.00 Labor & delivery days (see instructions)			0	0		32.00
33.00 LTCH non-covered days		0				33.00

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	309	1.00
2.00 HMO					0	2.00
3.00 HMO IPF						3.00
4.00 HMO IRF						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	115.12	0.00	0	309	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0.00	0.00	0	187	16.00
17.00 SUBPROVIDER - IRF	0.00	0.00	0.00	0	0	17.00
18.00 SUBPROVIDER	0.00	18.47	0.00	0	0	18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						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	133.59	0.00			27.00
28.00 Observation Bed Days						28.00
28.01 SUBPROVIDER - IPF						28.01
28.02 SUBPROVIDER - IRF						28.02
28.03 SUBPROVIDER						28.03
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151325

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
1/26/2012 12:42 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)	67	587	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)	67	587	14.00
15.00 CAH visits			15.00
16.00 SUBPROVIDER - IPF	0	219	16.00
17.00 SUBPROVIDER - IRF	0	0	17.00
18.00 SUBPROVIDER	0	0	18.00
19.00 SKILLED NURSING FACILITY			19.00
20.00 NURSING FACILITY			20.00
21.00 OTHER LONG TERM CARE			21.00
22.00 HOME HEALTH AGENCY			22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)			23.00
24.00 HOSPICE			24.00
25.00 CMHC - CMHC			25.00
26.00 RURAL HEALTH CLINIC			26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER			26.25
27.00 Total (sum of lines 14-26)			27.00
28.00 Observation Bed Days			28.00
28.01 SUBPROVIDER - IPF			28.01
28.02 SUBPROVIDER - IRF			28.02
28.03 SUBPROVIDER			28.03
29.00 Ambulance Trips			29.00
30.00 Employee discount days (see instruction)			30.00
31.00 Employee discount days - IRF			31.00
32.00 Labor & delivery days (see instructions)			32.00
33.00 LTCH non-covered days			33.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 151325	Period: From 07/01/2010 To 06/30/2011	Worksheet S-10 Date/Time Prepared: 1/26/2012 12:42 pm
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			1.00	
<b>Uncompensated and indigent care cost computation</b>				
1.00	Cost to charge ratio (Worksheet C, Part I line 200 column 3 divided by line 200 column 8)		0.435933	1.00
<b>Medicaid (see instructions for each line)</b>				
2.00	Net revenue from Medicaid		816,608	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		5,621,982	6.00
7.00	Medicaid cost (line 1 times line 6)		2,450,807	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		1,634,199	8.00
<b>State Children's Health Insurance Program (SCHIP) (see instructions for each line)</b>				
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
<b>Other state or local government indigent care program (see instructions for each line)</b>				
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
<b>Uncompensated care (see instructions for each line)</b>				
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		11,309	18.00
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		1,634,199	19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)
		1.00	2.00	3.00
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	925,684	1,385,849	2,311,533
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	403,536	604,137	1,007,673
22.00	Partial payment by patients approved for charity care	4,087	6,084	10,171
23.00	Cost of charity care (line 21 minus line 22)	399,449	598,053	997,502
				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)		266,644	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		266,644	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)		0	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)		0	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)		997,502	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		2,631,701	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151325

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

Worksheet A

Date/Time Prepared:  
1/26/2012 12:42 pm

Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassification	Reclassified	
	1.00	2.00	3.00	4.00	Trial Balance	(col. 3 + col. 4)
<b>GENERAL SERVICE COST CENTERS</b>						
1.00		887,834	887,834	0	887,834	1.00
2.00		274,238	274,238	0	274,238	2.00
3.00		0	0	0	0	3.00
4.00	25,270	1,829,015	1,854,285	0	1,854,285	4.00
5.01	29,969	30,414	60,383	0	60,383	5.01
5.02	29,434	21,939	51,373	0	51,373	5.02
5.03	334,967	286,387	621,354	2,118	623,472	5.03
5.04	667,464	769,897	1,437,361	-83,690	1,353,671	5.04
6.00	0	0	0	0	0	6.00
7.00	145,446	561,965	707,411	0	707,411	7.00
8.00	0	49,660	49,660	0	49,660	8.00
9.00	136,427	21,132	157,559	0	157,559	9.00
10.00	135,472	118,001	253,473	-30,921	222,552	10.00
11.00	0	0	0	30,921	30,921	11.00
12.00	0	0	0	0	0	12.00
13.00	0	0	0	83,690	83,690	13.00
14.00	0	0	0	0	0	14.00
15.00	57,682	120,363	178,045	0	178,045	15.00
16.00	111,590	56,146	167,736	0	167,736	16.00
17.00	0	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	1,033,690	69,737	1,103,427	0	1,103,427	30.00
31.00	0	0	0	0	0	31.00
40.00	739,970	442,480	1,182,450	0	1,182,450	40.00
41.00	0	0	0	0	0	41.00
42.00	0	0	0	0	0	42.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	146,484	233,930	380,414	0	380,414	50.00
51.00	0	0	0	0	0	51.00
52.00	0	0	0	0	0	52.00
53.00	0	259,102	259,102	0	259,102	53.00
54.00	550,471	622,195	1,172,666	0	1,172,666	54.00
56.00	0	0	0	0	0	56.00
57.00	0	0	0	0	0	57.00
58.00	0	0	0	0	0	58.00
59.00	0	0	0	0	0	59.00
60.00	426,162	484,294	910,456	0	910,456	60.00
60.01	0	0	0	0	0	60.01
63.00	0	0	0	0	0	63.00
64.00	0	0	0	0	0	64.00
65.00	108,733	14,429	123,162	0	123,162	65.00
66.00	212,049	25,956	238,005	0	238,005	66.00
67.00	0	0	0	0	0	67.00
68.00	0	0	0	0	0	68.00
69.00	0	31,356	31,356	0	31,356	69.00
70.00	0	0	0	0	0	70.00
71.00	0	105,052	105,052	70,860	175,912	71.00
72.00	0	91,152	91,152	-70,860	20,292	72.00
73.00	0	380,455	380,455	0	380,455	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	0	0	0	0	0	90.00
91.00	1,296,809	571,225	1,868,034	-2,118	1,865,916	91.00
92.00	0	0	0	0	0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	6,188,089	8,358,354	14,546,443	0	14,546,443	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00	0	0	0	0	0	190.00
192.00	0	0	0	0	0	192.00
194.00	55,355	13,593	68,948	0	68,948	194.00
194.01	72,045	24,026	96,071	0	96,071	194.01
194.02	0	214	214	0	214	194.02
194.03	0	0	0	0	0	194.03
200.00	6,315,489	8,396,187	14,711,676	0	14,711,676	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151325

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

Worksheet A

Date/Time Prepared:  
1/26/2012 12:42 pm

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
		6.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	CAP REL COSTS-BLDG & FIXT	119,621	1,007,455	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	-70,778	203,460	2.00
3.00	OTHER CAP RELATED COST	0	0	3.00
4.00	EMPLOYEE BENEFITS	-23,711	1,830,574	4.00
5.01	NONPATIENT TELEPHONES	-3,357	57,026	5.01
5.02	PURCHASING RECEIVING AND STORES	-165	51,208	5.02
5.03	CASHIERING/ACCOUNTS RECEIVABLE	-73,701	549,771	5.03
5.04	OTHER ADMINISTRATIVE AND GENERAL	1,187,940	2,541,611	5.04
6.00	MAINTENANCE & REPAIRS	0	0	6.00
7.00	OPERATION OF PLANT	-450	706,961	7.00
8.00	LAUNDRY & LINEN SERVICE	0	49,660	8.00
9.00	HOUSEKEEPING	-8,040	149,519	9.00
10.00	DIETARY	-32,244	190,308	10.00
11.00	CAFETERIA	0	30,921	11.00
12.00	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	NURSING ADMINISTRATION	0	83,690	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	14.00
15.00	PHARMACY	0	178,045	15.00
16.00	MEDICAL RECORDS & LIBRARY	-50	167,686	16.00
17.00	SOCIAL SERVICE	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	ADULTS & PEDIATRICS	0	1,103,427	30.00
31.00	INTENSIVE CARE UNIT	0	0	31.00
40.00	SUBPROVIDER - IPF	-9,824	1,172,626	40.00
41.00	SUBPROVIDER - IRF	0	0	41.00
42.00	SUBPROVIDER	0	0	42.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	OPERATING ROOM	-165,116	215,298	50.00
51.00	RECOVERY ROOM	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	ANESTHESIOLOGY	-253,000	6,102	53.00
54.00	RADIOLOGY - DIAGNOSTIC	-188,297	984,369	54.00
56.00	RADIOISOTOPE	0	0	56.00
57.00	CT SCAN	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	59.00
60.00	LABORATORY	-30	910,426	60.00
60.01	BLOOD LABORATORY	0	0	60.01
63.00	BLOOD STORING, PROCESSING, & TRANS.	0	0	63.00
64.00	INTRAVENOUS THERAPY	0	0	64.00
65.00	RESPIRATORY THERAPY	-4,375	118,787	65.00
66.00	PHYSICAL THERAPY	-30,136	207,869	66.00
67.00	OCCUPATIONAL THERAPY	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	68.00
69.00	ELECTROCARDIOLOGY	-26,347	5,009	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	175,912	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	20,292	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	380,455	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	CLINIC	0	0	90.00
91.00	EMERGENCY	-299,523	1,566,393	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
118.00	SUBTOTALS (SUM OF LINES 1-117)	118,417	14,664,860	118.00
<b>NONREIMBURSABLE COST CENTERS</b>				
190.00	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
194.00	OTHER NRCC - PHYSICIAN CLINIC	0	68,948	194.00
194.01	OTHER NRCC - JAIL	0	96,071	194.01
194.02	OTHER NRCC - PUBLIC RELATIONS	0	214	194.02
194.03	OTHER NRCC - DR. OFFICE	0	0	194.03
200.00	TOTAL (SUM OF LINES 118-199)	118,417	14,830,093	200.00

RECLASSIFICATIONS

Provider CCN: 151325

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

Worksheet A-6

Date/Time Prepared:  
1/26/2012 12:42 pm

		Increases				
		Cost Center	Line #	Salary	Other	
		2.00	3.00	4.00	5.00	
<b>A - RECLASS NURSING ADMIN SALARIES</b>						
1.00	NURSING ADMINISTRATION		13.00	83,690	0	1.00
	TOTALS			83,690	0	
<b>B - RECLASS CAFETERIA EXPENSE</b>						
1.00	CAFETERIA		11.00	16,526	14,395	1.00
	TOTALS			16,526	14,395	
<b>C - ADMITTING HOURS IN ER RECLASS</b>						
1.00	CASHIERING/ACCOUNTS RECEIVABLE		5.03	2,118	0	1.00
	TOTALS			2,118	0	
<b>D - IMPLANTABLE DEVICES</b>						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS		71.00	0	70,860	1.00
	TOTALS			0	70,860	
500.00	Grand Total: Increases			102,334	85,255	500.00

RECLASSIFICATIONS

Provider CCN: 151325

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

Worksheet A-6

Date/Time Prepared:  
1/26/2012 12:42 pm

		Decreases					
	Cost Center	Line #	Salary	Other	wkst. A-7	Ref.	
	6.00	7.00	8.00	9.00	10.00		
<b>A - RECLASS NURSING ADMIN SALARIES</b>							
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	83,690	0	0		1.00
	TOTALS		83,690	0			
<b>B - RECLASS CAFETERIA EXPENSE</b>							
1.00	DIETARY	10.00	16,526	14,395	0		1.00
	TOTALS		16,526	14,395			
<b>C - ADMITTING HOURS IN ER RECLASS</b>							
1.00	EMERGENCY	91.00	2,118	0	0		1.00
	TOTALS		2,118	0			
<b>D - IMPLANTABLE DEVICES</b>							
1.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	72.00	0	70,860	0		1.00
	TOTALS		0	70,860			
500.00	Grand Total: Decreases		102,334	85,255			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151325

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

Worksheet A-7  
Parts I-III  
Date/Time Prepared:  
1/26/2012 12:42 pm

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	468,488	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	2.00
3.00	Buildings and Fixtures	10,890,574	44,792	0	44,792	3.00
4.00	Building Improvements	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	5.00
6.00	Movable Equipment	7,758,967	221,102	0	221,102	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	19,118,029	265,894	0	265,894	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	19,118,029	265,894	0	265,894	10.00
<b>SUMMARY OF CAPITAL</b>						
Cost Center Description		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)
		9.00	10.00	11.00	12.00	13.00
<b>PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2</b>						
1.00	CAP REL COSTS-BLDG & FIXT	887,834	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	123,517	149,459	1,262	2.00
3.00	Total (sum of lines 1-2)	887,834	123,517	149,459	1,262	3.00
<b>COMPUTATION OF RATIOS</b>						
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
<b>PART III - RECONCILIATION OF CAPITAL COSTS CENTERS</b>						
1.00	CAP REL COSTS-BLDG & FIXT	10,935,366	0	10,935,366	0.578119	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	7,980,069	0	7,980,069	0.421881	2.00
3.00	Total (sum of lines 1-2)	18,915,435	0	18,915,435	1.000000	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS		Provider CCN: 151325	Period: From 07/01/2010 To 06/30/2011	Worksheet A-7 Parts I-III Date/Time Prepared: 1/26/2012 12:42 pm
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		Ending Balance	Fully Depreciated Assets			
		6.00	7.00			
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	468,488	0		1.00	
2.00	Land Improvements	0	0		2.00	
3.00	Buildings and Fixtures	10,935,366	0		3.00	
4.00	Building Improvements	0	0		4.00	
5.00	Fixed Equipment	0	0		5.00	
6.00	Movable Equipment	7,980,069	0		6.00	
7.00	HIT designated Assets	0	0		7.00	
8.00	Subtotal (sum of lines 1-7)	19,383,923	0		8.00	
9.00	Reconciling Items	0	0		9.00	
10.00	Total (line 8 minus line 9)	19,383,923	0		10.00	
<b>SUMMARY OF CAPITAL</b>						
Cost Center Description		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)			
		14.00	15.00			
<b>PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2</b>						
1.00	CAP REL COSTS-BLDG & FIXT	0	887,834		1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	0	274,238		2.00	
3.00	Total (sum of lines 1-2)	0	1,162,072		3.00	
<b>ALLOCATION OF OTHER CAPITAL</b>						
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
<b>PART III - RECONCILIATION OF CAPITAL COSTS CENTERS</b>						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	968,656	0
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	123,517
3.00	Total (sum of lines 1-2)	0	0	0	968,656	123,517

RECONCILIATION OF CAPITAL COSTS CENTERS	Provider CCN: 151325	Period: From 07/01/2010 To 06/30/2011	Worksheet A-7 Parts I-III Date/Time Prepared: 1/26/2012 12:42 pm
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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		
<b>PART III - RECONCILIATION OF CAPITAL COSTS CENTERS</b>							
1.00	CAP REL COSTS-BLDG & FIXT	38,799	0	0	0	1,007,455	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	78,681	1,262	0	0	203,460	2.00
3.00	Total (sum of lines 1-2)	117,480	1,262	0	0	1,210,915	3.00

		Expense Classification on Worksheet A To/From which the Amount is to be Adjusted			
		Basis/Code (2)	Amount	Cost Center	Line #
		1.00	2.00	3.00	4.00
1.00	Investment income - buildings and fixtures (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00 1.00
2.00	Investment income - movable equipment (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00 2.00
3.00	Investment income - other (chapter 2)	B	-8,863	OTHER ADMINISTRATIVE AND GENERAL	5.04 3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00 4.00
5.00	Refunds and rebates of expenses (chapter 8)	B	-165	PURCHASING RECEIVING AND STORES	5.02 5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00 6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00 7.00
8.00	Television and radio service (chapter 21)		0		0.00 8.00
9.00	Parking lot (chapter 21)		0		0.00 9.00
10.00	Provider-based physician adjustment	A-8-2	-936,658		10.00 10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00 11.00
12.00	Related organization transactions (chapter 10)	A-8-1	1,367,811		12.00 12.00
13.00	Laundry and linen service		0		0.00 13.00
14.00	Cafeteria-employees and guests	B	-27,890	DIETARY	10.00 14.00
15.00	Rental of quarters to employee and others		0		0.00 15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00 16.00
17.00	Sale of drugs to other than patients		0		0.00 17.00
18.00	Sale of medical records and abstracts	B	-198	MEDICAL RECORDS & LIBRARY	16.00 18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00 19.00
20.00	Vending machines	B	-4,354	DIETARY	10.00 20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00 21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00 22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00 23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00 24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00 25.00
26.00	Depreciation - buildings and fixtures		0	0CAP REL COSTS-BLDG & FIXT	1.00 26.00
27.00	Depreciation - movable equipment		0	0CAP REL COSTS-MVBLE EQUIP	2.00 27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00 28.00
29.00	Physicians' assistant		0		0.00 29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00 30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00 31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00 32.00
33.00	NON-ALLOWABLE CED IN PSYCH MAN. FEE	A	-9,822	SUBPROVIDER - IPF	40.00 33.00
34.00	PHYSICIAN BILLING COSTS	A	-73,701	CASHIERING/ACCOUNTS RECEIVABLE	5.03 34.00
35.00	PHYSICIAN BILLING BENEFITS	A	-14,551	EMPLOYEE BENEFITS	4.00 35.00
36.00	UNNECESSARY BORROWING	A	-73,040	CAP REL COSTS-MVBLE EQUIP	2.00 36.00
37.00	CRNA BILLING FEES	A	-2	SUBPROVIDER - IPF	40.00 37.00
38.00	TELEPHONE SERVICES	A	-1,668	NONPATIENT TELEPHONES	5.01 38.00
39.00	TELEPHONE OPERATOR SALARY	A	-1,689	NONPATIENT TELEPHONES	5.01 39.00
40.00	TELEPHONE OPERATOR BENEFITS	A	-494	EMPLOYEE BENEFITS	4.00 40.00
41.00	NON-ALLOWABLE COMMUNITY PROJECTS	A	-8,995	OTHER ADMINISTRATIVE AND GENERAL	5.04 41.00
42.00	AHA DUES	A	-123	OTHER ADMINISTRATIVE AND GENERAL	5.04 42.00
43.00	NON-ALLOWABLE ADVERTISING	A	-447	OTHER ADMINISTRATIVE AND GENERAL	5.04 43.00
44.00	OTHER OPERATING REVENUE	B	-1,474	OTHER ADMINISTRATIVE AND GENERAL	5.04 44.00
45.00	SMMC RELATED PARTY INTEREST	A	-45,292	OTHER ADMINISTRATIVE AND GENERAL	5.04 45.00
46.00	OTHER EXERCISE REVENUE	B	-30,136	PHYSICAL THERAPY	66.00 46.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 151325

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

Worksheet A-8

Date/Time Prepared:  
1/26/2012 12:42 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
47.00	OTHER HOUSEKEEPING REVENUE	B	-8,040	HOUSEKEEPING	9.00 47.00
48.00	OTHER MAINTENANCE REVENUE	B	-450	OPERATION OF PLANT	7.00 48.00
49.00	OTHER LAB REVENUE	B	-30	LABORATORY	60.00 49.00
49.01	OTHER EDUCATION REVENUE	B	-30	OTHER ADMINISTRATIVE AND GENERAL	5.04 49.01
49.02	INCOME - GENESIS	B	-1,430	OTHER ADMINISTRATIVE AND GENERAL	5.04 49.02
49.03	MEDICAL RECORDS	A	148	MEDICAL RECORDS & LIBRARY	16.00 49.03
49.04			0		0.00 49.04
49.05			0		0.00 49.05
49.06			0		0.00 49.06
49.07			0		0.00 49.07
49.08			0		0.00 49.08
49.09			0		0.00 49.09
49.10			0		0.00 49.10
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200.)		118,417		

ADJUSTMENTS TO EXPENSES

Provider CCN: 151325

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

Worksheet A-8

Date/Time Prepared:  
1/26/2012 12:42 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)	11	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-ALLOWABLE CED IN PSYCH MAN. FEE	0	33.00
34.00	PHYSICIAN BILLING COSTS	0	34.00
35.00	PHYSICIAN BILLING BENEFITS	0	35.00
36.00	UNNECESSARY BORROWING	11	36.00
37.00	CRNA BILLING FEES	0	37.00
38.00	TELEPHONE SERVICES	0	38.00
39.00	TELEPHONE OPERATOR SALARY	0	39.00
40.00	TELEPHONE OPERATOR BENEFITS	0	40.00
41.00	NON-ALLOWABLE COMMUNITY PROJECTS	0	41.00
42.00	AHA DUES	0	42.00
43.00	NON-ALLOWABLE ADVERTISING	0	43.00
44.00	OTHER OPERATING REVENUE	0	44.00
45.00	SMMC RELATED PARTY INTEREST	0	45.00
46.00	OTHER EXERCISE REVENUE	0	46.00
47.00	OTHER HOUSEKEEPING REVENUE	0	47.00
48.00	OTHER MAINTENANCE REVENUE	0	48.00
49.00	OTHER LAB REVENUE	0	49.00
49.01	OTHER EDUCATION REVENUE	0	49.01
49.02	INCOME - GENESIS	0	49.02
49.03	MEDICAL RECORDS	0	49.03
49.04		0	49.04
49.05		0	49.05
49.06		0	49.06
49.07		0	49.07
49.08		0	49.08
49.09		0	49.09
49.10		0	49.10

ADJUSTMENTS TO EXPENSES		Provider CCN: 151325	Period: From 07/01/2010 To 06/30/2011	Worksheet A-8 Date/Time Prepared: 1/26/2012 12:42 pm
		Wkst. A-7 Ref. 5.00		
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: 151325	Period: From 07/01/2010 To 06/30/2011	Worksheet A-8-1 Date/Time Prepared: 1/26/2012 12:42 pm
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	Line No.	Cost Center	Expense Items	
	1.00	2.00	3.00	
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>				
1.00	5.04	OTHER ADMINISTRATIVE AND GENERAL	SMHS HO DIRECT COSTS	1.00
2.00	1.00	CAP REL COSTS-BLDG & FIXT	SMHS HO POOLED COSTS	2.00
3.00	5.04	OTHER ADMINISTRATIVE AND GENERAL	SMHS HO POOLED COSTS	3.00
4.00	5.04	OTHER ADMINISTRATIVE AND GENERAL	SMMC HO FUNCTIONAL COSTS	4.00
4.01	5.04	OTHER ADMINISTRATIVE AND GENERAL	MISSION HEALTH FEE	4.01
4.02	1.00	CAP REL COSTS-BLDG & FIXT	ASCENSION BUILD AND INTER	4.02
4.03	2.00	CAP REL COSTS-MVBLE EQUIP	ASCENSION EQUIPMENT	4.03
4.04	4.00	EMPLOYEE BENEFITS	ASCENSION BENEFITS	4.04
4.05	5.04	OTHER ADMINISTRATIVE AND GENERAL	ASCENSION A&G AND INTEREST	4.05
4.06	8.00	LAUNDRY & LINEN SERVICE	LINEN PASS THROUGH	4.06
4.07	15.00	PHARMACY	PHARMACY PASS THROUGH	4.07
4.08	5.04	OTHER ADMINISTRATIVE AND GENERAL	A&G PASS THROUGH	4.08
4.09	54.00	RADIOLOGY - DIAGNOSTIC	RADIOLOGY PASS THROUGH	4.09
4.10	60.00	LABORATORY	LAB PASS THROUGH	4.10
4.11	50.00	OPERATING ROOM	OR PASS THROUGH	4.11
4.12	4.00	EMPLOYEE BENEFITS	PENSION ADJUSTMENT	4.12
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		0.00	6.00
7.00	B		0.00	7.00
8.00	B		0.00	8.00
9.00			0.00	9.00
10.00			0.00	10.00
100.00	G. Other (financial or non-financial) specify:			100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS  
 Provider CCN: 151325  
 Period: From 07/01/2010 To 06/30/2011  
 Worksheet A-8-1  
 Date/Time Prepared: 1/26/2012 12:42 pm

	Amount of Allowable Cost	Amount Included in Wks. A, column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	4.00	5.00	6.00	7.00	
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>					
1.00	245,677	0	245,677	0	1.00
2.00	80,822	0	80,822	9	2.00
3.00	521,083	0	521,083	0	3.00
4.00	780,506	0	780,506	0	4.00
4.01	0	469,632	-469,632	0	4.01
4.02	38,799	0	38,799	11	4.02
4.03	2,262	0	2,262	11	4.03
4.04	15,512	0	15,512	0	4.04
4.05	176,960	0	176,960	0	4.05
4.06	48,768	48,768	0	0	4.06
4.07	25,056	25,056	0	0	4.07
4.08	253,183	253,183	0	0	4.08
4.09	1,862	1,862	0	0	4.09
4.10	31,449	31,449	0	0	4.10
4.11	2,306	2,306	0	0	4.11
4.12	155,172	179,350	-24,178	0	4.12
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to worksheet A-8, column 2, line 12.	2,379,417	1,011,606	1,367,811	5.00

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

Related Organization(s) and/or Home Office			
Name	Percentage of Ownership	Type of Business	
	4.00	5.00	6.00

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

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

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

6.00	ASCENSION HEALT	100.00	HOME OFFICE	6.00
7.00	ASCENSION HEALT	100.00	DATA PROCESSING	7.00
8.00	MISSION HEALTH	0.00	EVANSVILLE H.O.	8.00
9.00		0.00		9.00
10.00		0.00		10.00
100.00	G. Other (financial or non-financial) specify:			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151325

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

Worksheet A-8-2

Date/Time Prepared:  
1/26/2012 12:42 pm

	wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
	1.00	2.00	3.00	4.00	
1.00	0.00		0	0	1.00
2.00	16.00	AGGREGATE FEES	4,250	0	2.00
3.00	50.00	AGGREGATE FEES	165,116	165,116	3.00
4.00	53.00	AGGREGATE FEES	253,000	253,000	4.00
5.00	54.00	AGGREGATE FEES	188,297	188,297	5.00
6.00	0.00		0	0	6.00
7.00	65.00	AGGREGATE FEES	4,375	4,375	7.00
8.00	69.00	AGGREGATE FEES	26,347	26,347	8.00
9.00	91.00	AGGREGATE FEES	880,949	299,523	9.00
10.00	0.00		0	0	10.00
200.00		TOTAL (lines 1.00 through 199.00)	1,522,334	936,658	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151325

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

Worksheet A-8-2

Date/Time Prepared:  
1/26/2012 12:42 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	0	0	0	0	1.00
2.00	4,250	0	0	0	0	2.00
3.00	0	0	0	0	0	3.00
4.00	0	0	0	0	0	4.00
5.00	0	0	0	0	0	5.00
6.00	0	0	0	0	0	6.00
7.00	0	0	0	0	0	7.00
8.00	0	0	0	0	0	8.00
9.00	581,426	0	0	0	0	9.00
10.00	0	0	0	0	0	10.00
200.00	585,676					200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151325

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

Worksheet A-8-2

Date/Time Prepared:  
1/26/2012 12:42 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	0	3.00
4.00	0	0	0	0	0	4.00
5.00	0	0	0	0	0	5.00
6.00	0	0	0	0	0	6.00
7.00	0	0	0	0	0	7.00
8.00	0	0	0	0	0	8.00
9.00	0	0	0	0	0	9.00
10.00	0	0	0	0	0	10.00
200.00	0	0	0	0	0	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151325

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

Worksheet A-8-2

Date/Time Prepared:  
1/26/2012 12:42 pm

	RCE Disallowance	Adjustment	
	17.00	18.00	
1.00	0	0	1.00
2.00	0	0	2.00
3.00	0	165,116	3.00
4.00	0	253,000	4.00
5.00	0	188,297	5.00
6.00	0	0	6.00
7.00	0	4,375	7.00
8.00	0	26,347	8.00
9.00	0	299,523	9.00
10.00	0	0	10.00
200.00	0	936,658	200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 151325	Period: From 07/01/2010 To 06/30/2011	Worksheet A-8-3 Par Date/Time Prepared: 1/26/2012 12:43 pm
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Physical Therapy	Cost
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<b>PART I - GENERAL INFORMATION</b>		1.00	
1.00	Total number of weeks worked (excluding aides) (see instructions)	5	1.00
2.00	Line 1 multiplied by 15 hours per week	75	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)	0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)	0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)	0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)	0	6.00
7.00	Standard travel expense rate	4.85	7.00
8.00	Optional travel expense rate per mile	0.00	8.00

	Supervisors	Therapists	Assistants	Aides	Trainees	
	1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	107.00	95.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	84.25	73.26	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	36.63	36.63	0.00		11.00
12.00	Number of travel hours (provider site)	0	0	0		12.00
12.01	Number of travel hours (offsite)	0	0	0		12.01
13.00	Number of miles driven (provider site)	0	0	0		13.00
13.01	Number of miles driven (offsite)	0	0	0		13.01

		1.00	
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<b>Part II - SALARY EQUIVALENCY COMPUTATION</b>			
14.00	Supervisors (column 1, line 9 times column 1, line 10)	9,015	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)	6,960	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)	0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	15,975	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)	0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)	0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	15,975	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.			
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)	0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	0	22.00
23.00	Total salary equivalency (see instructions)	15,975	23.00

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

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

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

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

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 151325	Period: From 07/01/2010 To 06/30/2011	Worksheet A-8-3 Par Date/Time Prepared: 1/26/2012 12:43 pm
		Physical Therapy	Cost

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

**PART V - OVERTIME COMPUTATION**

47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00	0.00	0.00	48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00	0.00	0.00	49.00
<b>CALCULATION OF LIMIT</b>								
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	0.00	51.00
<b>DETERMINATION OF OVERTIME ALLOWANCE</b>								
52.00	Adjusted hourly salary equivalency amount (see instructions)	73.26	0.00	0.00	0.00	0.00	0.00	52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0	0	0	53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0	0	0	54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0	0	0	55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	0	56.00

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

57.00	Salary equivalency amount (from line 23)						15,975	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))						0	58.00
59.00	Travel allowance and expense - offsite services (from lines 44, 45, or 46)						0	59.00
60.00	Overtime allowance (from column 5, line 56)						0	60.00
61.00	Equipment cost (see instructions)						0	61.00
62.00	Supplies (see instructions)						0	62.00
63.00	Total allowance (sum of lines 57-62)						15,975	63.00
64.00	Total cost of outside supplier services (from your records)						11,297	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)						0	65.00

**LINE 33 CALCULATION**

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

**LINE 34 CALCULATION**

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

**LINE 35 CALCULATION**

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

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151325

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

Worksheet B  
Part I  
Date/Time Prepared:  
1/26/2012 12:42 pm

Cost Center Description	Net Expenses for Cost Allocation (from wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	NONPATIENT TELEPHONES	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	CAP REL COSTS-BLDG & FIXT	1,007,455	1,007,455			1.00
2.00	CAP REL COSTS-MVBLE EQUIP	203,460		203,460		2.00
4.00	EMPLOYEE BENEFITS	1,830,574	15,215	3,073	1,848,862	4.00
5.01	NONPATIENT TELEPHONES	57,026	4,251	859	8,911	5.01
5.02	PURCHASING RECEIVING AND STORES	51,208	20,901	4,221	8,752	5.02
5.03	CASHIERING/ACCOUNTS RECEIVABLE	549,771	27,121	5,477	99,596	5.03
5.04	OTHER ADMINISTRATIVE AND GENERAL	2,541,611	66,504	13,431	174,204	5.04
6.00	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	OPERATION OF PLANT	706,961	76,989	15,548	38,332	7.00
8.00	LAUNDRY & LINEN SERVICE	49,660	3,294	665	4,914	8.00
9.00	HOUSEKEEPING	149,519	11,756	2,374	40,564	9.00
10.00	DIETARY	190,308	52,205	10,543	65,164	10.00
11.00	CAFETERIA	30,921	7,122	1,438	0	11.00
12.00	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	NURSING ADMINISTRATION	83,690	0	0	0	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	14,531	2,935	0	14.00
15.00	PHARMACY	178,045	16,910	3,415	17,151	15.00
16.00	MEDICAL RECORDS & LIBRARY	167,686	29,281	5,913	33,179	16.00
17.00	SOCIAL SERVICE	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	ADULTS & PEDIATRICS	1,103,427	103,713	20,945	307,349	30.00
31.00	INTENSIVE CARE UNIT	0	0	0	0	31.00
40.00	SUBPROVIDER - IPF	1,172,626	81,513	16,462	220,017	40.00
41.00	SUBPROVIDER - IRF	0	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	0	42.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	OPERATING ROOM	215,298	104,343	21,074	43,554	50.00
51.00	RECOVERY ROOM	0	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	6,102	0	0	0	53.00
54.00	RADIOLOGY - DIAGNOSTIC	984,369	79,613	16,078	163,673	54.00
56.00	RADIOISOTOPE	0	0	0	0	56.00
57.00	CT SCAN	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	LABORATORY	910,426	32,343	6,532	126,712	60.00
60.01	BLOOD LABORATORY	0	0	0	0	60.01
63.00	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	63.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	118,787	13,574	2,741	32,330	65.00
66.00	PHYSICAL THERAPY	207,869	62,950	12,713	63,049	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	5,009	5,782	1,168	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	175,912	0	0	0	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	20,292	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	380,455	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	CLINIC	0	0	0	0	90.00
91.00	EMERGENCY	1,566,393	37,811	7,636	384,952	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1-117)	14,664,860	867,722	175,241	1,832,403	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	7,518	1,518	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00	OTHER NRCC - PHYSICIAN CLINIC	68,948	83,113	16,785	16,459	194.00
194.01	OTHER NRCC - JAIL	96,071	0	0	0	194.01
194.02	OTHER NRCC - PUBLIC RELATIONS	214	6,630	1,339	0	194.02
194.03	OTHER NRCC - DR. OFFICE	0	42,472	8,577	0	194.03
200.00	Cross Foot Adjustments	0	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	14,830,093	1,007,455	203,460	1,848,862	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151325

Period:  
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Cost Center Description	PURCHASING RECEIVING AND STORES	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	
	5.02	5.03	5A.03	5.04	6.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00						1.00
2.00						2.00
4.00						4.00
5.01						5.01
5.02	85,082					5.02
5.03	153	689,847				5.03
5.04	4,572	0	2,814,293	2,814,293		5.04
6.00	0	0	0	0	0	6.00
7.00	20,583	0	861,386	201,750	0	7.00
8.00	1,441	0	60,569	14,186	0	8.00
9.00	6,909	0	211,419	49,518	0	9.00
10.00	9,504	0	328,913	77,037	0	10.00
11.00	0	0	39,778	9,317	0	11.00
12.00	0	0	0	0	0	12.00
13.00	0	0	84,285	19,741	0	13.00
14.00	0	0	17,763	4,160	0	14.00
15.00	224	0	215,745	50,531	0	15.00
16.00	72	0	241,185	56,489	0	16.00
17.00	0	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	15,479	62,346	1,617,421	378,826	0	30.00
31.00	0	0	0	0	0	31.00
40.00	6,548	83,513	1,583,949	370,986	0	40.00
41.00	0	0	0	0	0	41.00
42.00	0	0	0	0	0	42.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	2,452	29,550	420,433	98,472	0	50.00
51.00	0	0	0	0	0	51.00
52.00	0	0	0	0	0	52.00
53.00	58	1,900	8,060	1,888	0	53.00
54.00	1,800	156,852	1,407,141	329,575	0	54.00
56.00	0	0	0	0	0	56.00
57.00	0	0	0	0	0	57.00
58.00	0	0	0	0	0	58.00
59.00	0	0	0	0	0	59.00
60.00	7,093	80,192	1,166,271	273,159	0	60.00
60.01	0	0	0	0	0	60.01
63.00	0	0	0	0	0	63.00
64.00	0	0	0	0	0	64.00
65.00	172	14,617	184,005	43,097	0	65.00
66.00	1,682	30,735	381,673	89,394	0	66.00
67.00	0	0	0	0	0	67.00
68.00	0	0	0	0	0	68.00
69.00	0	20,213	32,172	7,535	0	69.00
70.00	0	0	0	0	0	70.00
71.00	0	36,268	212,180	49,696	0	71.00
72.00	0	1,624	21,916	5,133	0	72.00
73.00	0	59,229	441,170	103,329	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	0	0	0	0	0	90.00
91.00	5,332	112,808	2,117,607	495,979	0	91.00
92.00	0	0	0	0	0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	84,074	689,847	14,469,334	2,729,798	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00	0	0	9,333	2,186	0	190.00
192.00	0	0	0	0	0	192.00
194.00	252	0	195,367	45,758	0	194.00
194.01	584	0	96,655	22,638	0	194.01
194.02	172	0	8,355	1,957	0	194.02
194.03	0	0	51,049	11,956	0	194.03
200.00	0	0	0	0	0	200.00
201.00	0	0	0	0	0	201.00
202.00	85,082	689,847	14,830,093	2,814,293	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151325

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

Worksheet B  
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Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
	7.00	8.00	9.00	10.00	11.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	EMPLOYEE BENEFITS					4.00
5.01	NONPATIENT TELEPHONES					5.01
5.02	PURCHASING RECEIVING AND STORES					5.02
5.03	CASHIERING/ACCOUNTS RECEIVABLE					5.03
5.04	OTHER ADMINISTRATIVE AND GENERAL					5.04
6.00	MAINTENANCE & REPAIRS					6.00
7.00	OPERATION OF PLANT	1,063,136				7.00
8.00	LAUNDRY & LINEN SERVICE	4,397	79,152			8.00
9.00	HOUSEKEEPING	15,692	3,903	280,532		9.00
10.00	DIETARY	69,684	0	0	475,634	10.00
11.00	CAFETERIA	9,506	0	2,595	0	61,196
12.00	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00	NURSING ADMINISTRATION	0	0	0	0	0
14.00	CENTRAL SERVICES & SUPPLY	19,396	0	0	0	0
15.00	PHARMACY	22,571	0	1,568	0	596
16.00	MEDICAL RECORDS & LIBRARY	39,084	0	9,308	0	2,752
17.00	SOCIAL SERVICE	0	0	0	0	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	ADULTS & PEDIATRICS	138,437	30,153	83,233	346,039	17,747
31.00	INTENSIVE CARE UNIT	0	0	0	0	0
40.00	SUBPROVIDER - IPF	108,804	14,389	62,972	129,595	12,486
41.00	SUBPROVIDER - IRF	0	0	0	0	0
42.00	SUBPROVIDER	0	0	0	0	0
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	OPERATING ROOM	139,277	4,662	3,565	0	2,764
51.00	RECOVERY ROOM	0	0	0	0	0
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0
53.00	ANESTHESIOLOGY	0	0	0	0	0
54.00	RADIOLOGY - DIAGNOSTIC	106,268	5,337	19,192	0	5,443
56.00	RADIOISOTOPE	0	0	0	0	0
57.00	CT SCAN	0	0	0	0	0
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	LABORATORY	43,171	408	16,939	0	7,449
60.01	BLOOD LABORATORY	0	0	0	0	0
63.00	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0
64.00	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	RESPIRATORY THERAPY	18,119	0	8,840	0	1,632
66.00	PHYSICAL THERAPY	84,025	3,899	7,557	0	2,676
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	SPEECH PATHOLOGY	0	0	0	0	0
69.00	ELECTROCARDIOLOGY	7,718	0	0	0	0
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	CLINIC	0	0	0	0	0
91.00	EMERGENCY	50,470	15,565	32,168	0	7,651
92.00	OBSERVATION BEDS (NON-DISTINCT PART)					
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1-117)	876,619	78,316	247,937	475,634	61,196
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	10,036	0	200	0	0
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
194.00	OTHER NRCC - PHYSICIAN CLINIC	110,939	836	18,764	0	0
194.01	OTHER NRCC - JAIL	0	0	0	0	0
194.02	OTHER NRCC - PUBLIC RELATIONS	8,850	0	2,766	0	0
194.03	OTHER NRCC - DR. OFFICE	56,692	0	10,865	0	0
200.00	Cross Foot Adjustments					
201.00	Negative Cost Centers	0	0	0	0	0
202.00	TOTAL (sum lines 118-201)	1,063,136	79,152	280,532	475,634	61,196

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151325

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

Worksheet B  
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Cost Center Description		MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		12.00	13.00	14.00	15.00	16.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.01	NONPATIENT TELEPHONES						5.01
5.02	PURCHASING RECEIVING AND STORES						5.02
5.03	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	MAINTENANCE & REPAIRS						6.00
7.00	OPERATION OF PLANT						7.00
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING						9.00
10.00	DIETARY						10.00
11.00	CAFETERIA						11.00
12.00	MAINTENANCE OF PERSONNEL	0					12.00
13.00	NURSING ADMINISTRATION	0	104,026				13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	41,319			14.00
15.00	PHARMACY	0	0	0	291,011		15.00
16.00	MEDICAL RECORDS & LIBRARY	0	0	0	0	348,818	16.00
17.00	SOCIAL SERVICE	0	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	ADULTS & PEDIATRICS	0	31,914	0	1,565	31,524	30.00
31.00	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	SUBPROVIDER - IPF	0	22,453	0	0	42,227	40.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	0	0	42.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM	0	4,970	0	2,521	14,942	50.00
51.00	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	0	0	0	718	961	53.00
54.00	RADIOLOGY - DIAGNOSTIC	0	9,788	0	8,806	79,318	54.00
56.00	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	CT SCAN	0	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	0	13,395	0	59	40,548	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	63.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	0	2,934	0	52	7,391	65.00
66.00	PHYSICAL THERAPY	0	4,813	0	127	15,541	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	10,220	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	41,319	0	18,338	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	821	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	277,079	29,948	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	CLINIC	0	0	0	0	0	90.00
91.00	EMERGENCY	0	13,759	0	84	57,039	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	104,026	41,319	291,011	348,818	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	OTHER NRCC - PHYSICIAN CLINIC	0	0	0	0	0	194.00
194.01	OTHER NRCC - JAIL	0	0	0	0	0	194.01
194.02	OTHER NRCC - PUBLIC RELATIONS	0	0	0	0	0	194.02
194.03	OTHER NRCC - DR. OFFICE	0	0	0	0	0	194.03
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	104,026	41,319	291,011	348,818	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 151325	Period: From 07/01/2010 To 06/30/2011	Worksheet B Part I Date/Time Prepared: 1/26/2012 12:42 pm
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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	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00					1.00
2.00					2.00
4.00					4.00
5.01					5.01
5.02					5.02
5.03					5.03
5.04					5.04
6.00					6.00
7.00					7.00
8.00					8.00
9.00					9.00
10.00					10.00
11.00					11.00
12.00					12.00
13.00					13.00
14.00					14.00
15.00					15.00
16.00					16.00
17.00	0				17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	0	2,676,859	0	2,676,859	30.00
31.00	0	0	0	0	31.00
40.00	0	2,347,861	0	2,347,861	40.00
41.00	0	0	0	0	41.00
42.00	0	0	0	0	42.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	0	691,606	0	691,606	50.00
51.00	0	0	0	0	51.00
52.00	0	0	0	0	52.00
53.00	0	11,627	0	11,627	53.00
54.00	0	1,970,868	0	1,970,868	54.00
56.00	0	0	0	0	56.00
57.00	0	0	0	0	57.00
58.00	0	0	0	0	58.00
59.00	0	0	0	0	59.00
60.00	0	1,561,399	0	1,561,399	60.00
60.01	0	0	0	0	60.01
63.00	0	0	0	0	63.00
64.00	0	0	0	0	64.00
65.00	0	266,070	0	266,070	65.00
66.00	0	589,705	0	589,705	66.00
67.00	0	0	0	0	67.00
68.00	0	0	0	0	68.00
69.00	0	57,645	0	57,645	69.00
70.00	0	0	0	0	70.00
71.00	0	321,533	0	321,533	71.00
72.00	0	27,870	0	27,870	72.00
73.00	0	851,526	0	851,526	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	0	0	0	0	90.00
91.00	0	2,790,322	0	2,790,322	91.00
92.00	0	0	0	0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
118.00	0	14,164,891	0	14,164,891	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	0	21,755	0	21,755	190.00
192.00	0	0	0	0	192.00
194.00	0	371,664	0	371,664	194.00
194.01	0	119,293	0	119,293	194.01
194.02	0	21,928	0	21,928	194.02
194.03	0	130,562	0	130,562	194.03
200.00	0	0	0	0	200.00
201.00	0	0	0	0	201.00
202.00	0	14,830,093	0	14,830,093	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151325

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

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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	EMPLOYEE BENEFITS	0	15,215	3,073	18,288	18,288
5.01	NONPATIENT TELEPHONES	0	4,251	859	5,110	88
5.02	PURCHASING RECEIVING AND STORES	0	20,901	4,221	25,122	87
5.03	CASHIERING/ACCOUNTS RECEIVABLE	0	27,121	5,477	32,598	985
5.04	OTHER ADMINISTRATIVE AND GENERAL	0	66,504	13,431	79,935	1,723
6.00	MAINTENANCE & REPAIRS	0	0	0	0	0
7.00	OPERATION OF PLANT	0	76,989	15,548	92,537	379
8.00	LAUNDRY & LINEN SERVICE	0	3,294	665	3,959	49
9.00	HOUSEKEEPING	0	11,756	2,374	14,130	401
10.00	DIETARY	0	52,205	10,543	62,748	645
11.00	CAFETERIA	0	7,122	1,438	8,560	0
12.00	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00	NURSING ADMINISTRATION	0	0	0	0	0
14.00	CENTRAL SERVICES & SUPPLY	0	14,531	2,935	17,466	0
15.00	PHARMACY	0	16,910	3,415	20,325	170
16.00	MEDICAL RECORDS & LIBRARY	0	29,281	5,913	35,194	328
17.00	SOCIAL SERVICE	0	0	0	0	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	ADULTS & PEDIATRICS	0	103,713	20,945	124,658	3,040
31.00	INTENSIVE CARE UNIT	0	0	0	0	0
40.00	SUBPROVIDER - IPF	0	81,513	16,462	97,975	2,176
41.00	SUBPROVIDER - IRF	0	0	0	0	0
42.00	SUBPROVIDER	0	0	0	0	0
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	OPERATING ROOM	0	104,343	21,074	125,417	431
51.00	RECOVERY ROOM	0	0	0	0	0
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0
53.00	ANESTHESIOLOGY	0	0	0	0	0
54.00	RADIOLOGY - DIAGNOSTIC	0	79,613	16,078	95,691	1,619
56.00	RADIOISOTOPE	0	0	0	0	0
57.00	CT SCAN	0	0	0	0	0
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	LABORATORY	0	32,343	6,532	38,875	1,253
60.01	BLOOD LABORATORY	0	0	0	0	0
63.00	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0
64.00	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	RESPIRATORY THERAPY	0	13,574	2,741	16,315	320
66.00	PHYSICAL THERAPY	0	62,950	12,713	75,663	624
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	SPEECH PATHOLOGY	0	0	0	0	0
69.00	ELECTROCARDIOLOGY	0	5,782	1,168	6,950	0
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	CLINIC	0	0	0	0	0
91.00	EMERGENCY	0	37,811	7,636	45,447	3,807
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	867,722	175,241	1,042,963	18,125
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	7,518	1,518	9,036	0
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
194.00	OTHER NRCC - PHYSICIAN CLINIC	0	83,113	16,785	99,898	163
194.01	OTHER NRCC - JAIL	0	0	0	0	0
194.02	OTHER NRCC - PUBLIC RELATIONS	0	6,630	1,339	7,969	0
194.03	OTHER NRCC - DR. OFFICE	0	42,472	8,577	51,049	0
200.00	Cross Foot Adjustments	0	0	0	0	0
201.00	Negative Cost Centers	0	0	0	0	0
202.00	TOTAL (sum lines 118-201)	0	1,007,455	203,460	1,210,915	18,288

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151325

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

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Cost Center Description		NONPATIENT TELEPHONES	PURCHASING RECEIVING AND STORES	CASHIERING/ACC OUNTS RECEIVABLE	OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	
		5.01	5.02	5.03	5.04	6.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.01	NONPATIENT TELEPHONES	5,198					5.01
5.02	PURCHASING RECEIVING AND STORES	0	25,209				5.02
5.03	CASHIERING/ACCOUNTS RECEIVABLE	565	45	34,193			5.03
5.04	OTHER ADMINISTRATIVE AND GENERAL	1,024	1,355	0	84,037		5.04
6.00	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	OPERATION OF PLANT	217	6,100	0	6,025	0	7.00
8.00	LAUNDRY & LINEN SERVICE	43	427	0	424	0	8.00
9.00	HOUSEKEEPING	22	2,047	0	1,479	0	9.00
10.00	DIETARY	87	2,816	0	2,300	0	10.00
11.00	CAFETERIA	22	0	0	278	0	11.00
12.00	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	NURSING ADMINISTRATION	43	0	0	589	0	13.00
14.00	CENTRAL SERVICES & SUPPLY	22	0	0	124	0	14.00
15.00	PHARMACY	0	66	0	1,509	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	370	21	0	1,687	0	16.00
17.00	SOCIAL SERVICE	0	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	ADULTS & PEDIATRICS	304	4,586	3,089	11,312	0	30.00
31.00	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	SUBPROVIDER - IPF	239	1,940	4,138	11,078	0	40.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	0	0	42.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM	304	726	1,464	2,941	0	50.00
51.00	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	0	17	94	56	0	53.00
54.00	RADIOLOGY - DIAGNOSTIC	348	533	7,784	9,842	0	54.00
56.00	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	CT SCAN	0	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	217	2,102	3,973	8,157	0	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	63.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	130	51	724	1,287	0	65.00
66.00	PHYSICAL THERAPY	196	498	1,523	2,669	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	1,002	225	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1,797	1,484	0	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	80	153	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	109	0	2,935	3,086	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	CLINIC	0	0	0	0	0	90.00
91.00	EMERGENCY	196	1,580	5,590	14,810	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00	SUBTOTALS (SUM OF LINES 1-117)	4,458	24,910	34,193	81,515	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	22	0	0	65	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	OTHER NRCC - PHYSICIAN CLINIC	718	75	0	1,366	0	194.00
194.01	OTHER NRCC - JAIL	0	173	0	676	0	194.01
194.02	OTHER NRCC - PUBLIC RELATIONS	0	51	0	58	0	194.02
194.03	OTHER NRCC - DR. OFFICE	0	0	0	357	0	194.03
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	5,198	25,209	34,193	84,037	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151325

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

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Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
	7.00	8.00	9.00	10.00	11.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	EMPLOYEE BENEFITS					4.00
5.01	NONPATIENT TELEPHONES					5.01
5.02	PURCHASING RECEIVING AND STORES					5.02
5.03	CASHIERING/ACCOUNTS RECEIVABLE					5.03
5.04	OTHER ADMINISTRATIVE AND GENERAL					5.04
6.00	MAINTENANCE & REPAIRS					6.00
7.00	OPERATION OF PLANT	105,258				7.00
8.00	LAUNDRY & LINEN SERVICE	435	5,337			8.00
9.00	HOUSEKEEPING	1,554	263	19,896		9.00
10.00	DIETARY	6,899	0	0	75,495	10.00
11.00	CAFETERIA	941	0	184	0	9,985
12.00	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00	NURSING ADMINISTRATION	0	0	0	0	0
14.00	CENTRAL SERVICES & SUPPLY	1,920	0	0	0	0
15.00	PHARMACY	2,235	0	111	0	97
16.00	MEDICAL RECORDS & LIBRARY	3,870	0	660	0	449
17.00	SOCIAL SERVICE	0	0	0	0	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	ADULTS & PEDIATRICS	13,706	2,033	5,904	54,925	2,897
31.00	INTENSIVE CARE UNIT	0	0	0	0	0
40.00	SUBPROVIDER - IPF	10,772	970	4,466	20,570	2,037
41.00	SUBPROVIDER - IRF	0	0	0	0	0
42.00	SUBPROVIDER	0	0	0	0	0
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	OPERATING ROOM	13,790	314	253	0	451
51.00	RECOVERY ROOM	0	0	0	0	0
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0
53.00	ANESTHESIOLOGY	0	0	0	0	0
54.00	RADIOLOGY - DIAGNOSTIC	10,521	360	1,361	0	888
56.00	RADIOISOTOPE	0	0	0	0	0
57.00	CT SCAN	0	0	0	0	0
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	LABORATORY	4,274	28	1,201	0	1,215
60.01	BLOOD LABORATORY	0	0	0	0	0
63.00	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0
64.00	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	RESPIRATORY THERAPY	1,794	0	627	0	266
66.00	PHYSICAL THERAPY	8,319	263	536	0	437
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	SPEECH PATHOLOGY	0	0	0	0	0
69.00	ELECTROCARDIOLOGY	764	0	0	0	0
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	CLINIC	0	0	0	0	0
91.00	EMERGENCY	4,997	1,050	2,281	0	1,248
92.00	OBSERVATION BEDS (NON-DISTINCT PART)					
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1-117)	86,791	5,281	17,584	75,495	9,985
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	994	0	14	0	0
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
194.00	OTHER NRCC - PHYSICIAN CLINIC	10,984	56	1,331	0	0
194.01	OTHER NRCC - JAIL	0	0	0	0	0
194.02	OTHER NRCC - PUBLIC RELATIONS	876	0	196	0	0
194.03	OTHER NRCC - DR. OFFICE	5,613	0	771	0	0
200.00	Cross Foot Adjustments					
201.00	Negative Cost Centers	0	0	0	0	0
202.00	TOTAL (sum lines 118-201)	105,258	5,337	19,896	75,495	9,985

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151325

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

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Cost Center Description		MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		12.00	13.00	14.00	15.00	16.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.01	NONPATIENT TELEPHONES						5.01
5.02	PURCHASING RECEIVING AND STORES						5.02
5.03	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	MAINTENANCE & REPAIRS						6.00
7.00	OPERATION OF PLANT						7.00
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING						9.00
10.00	DIETARY						10.00
11.00	CAFETERIA						11.00
12.00	MAINTENANCE OF PERSONNEL	0					12.00
13.00	NURSING ADMINISTRATION	0	632				13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	19,532			14.00
15.00	PHARMACY	0	0	0	24,513		15.00
16.00	MEDICAL RECORDS & LIBRARY	0	0	0	0	42,579	16.00
17.00	SOCIAL SERVICE	0	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	ADULTS & PEDIATRICS	0	195	0	132	3,849	30.00
31.00	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	SUBPROVIDER - IPF	0	136	0	0	5,156	40.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	0	0	42.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM	0	30	0	212	1,824	50.00
51.00	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	0	0	0	60	117	53.00
54.00	RADIOLOGY - DIAGNOSTIC	0	59	0	742	9,673	54.00
56.00	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	CT SCAN	0	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	0	81	0	5	4,951	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	63.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	0	18	0	4	902	65.00
66.00	PHYSICAL THERAPY	0	29	0	11	1,898	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	1,248	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	19,532	0	2,239	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	100	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	23,340	3,657	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	CLINIC	0	0	0	0	0	90.00
91.00	EMERGENCY	0	84	0	7	6,965	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	632	19,532	24,513	42,579	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	OTHER NRCC - PHYSICIAN CLINIC	0	0	0	0	0	194.00
194.01	OTHER NRCC - JAIL	0	0	0	0	0	194.01
194.02	OTHER NRCC - PUBLIC RELATIONS	0	0	0	0	0	194.02
194.03	OTHER NRCC - DR. OFFICE	0	0	0	0	0	194.03
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	632	19,532	24,513	42,579	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151325

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

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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	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00 CAP REL COSTS-BLDG & FIXT					1.00
2.00 CAP REL COSTS-MVBLE EQUIP					2.00
4.00 EMPLOYEE BENEFITS					4.00
5.01 NONPATIENT TELEPHONES					5.01
5.02 PURCHASING RECEIVING AND STORES					5.02
5.03 CASHIERING/ACCOUNTS RECEIVABLE					5.03
5.04 OTHER ADMINISTRATIVE AND GENERAL					5.04
6.00 MAINTENANCE & REPAIRS					6.00
7.00 OPERATION OF PLANT					7.00
8.00 LAUNDRY & LINEN SERVICE					8.00
9.00 HOUSEKEEPING					9.00
10.00 DIETARY					10.00
11.00 CAFETERIA					11.00
12.00 MAINTENANCE OF PERSONNEL					12.00
13.00 NURSING ADMINISTRATION					13.00
14.00 CENTRAL SERVICES & SUPPLY					14.00
15.00 PHARMACY					15.00
16.00 MEDICAL RECORDS & LIBRARY					16.00
17.00 SOCIAL SERVICE	0				17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00 ADULTS & PEDIATRICS	0	230,630	0	230,630	30.00
31.00 INTENSIVE CARE UNIT	0	0	0	0	31.00
40.00 SUBPROVIDER - IPF	0	161,653	0	161,653	40.00
41.00 SUBPROVIDER - IRF	0	0	0	0	41.00
42.00 SUBPROVIDER	0	0	0	0	42.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00 OPERATING ROOM	0	148,157	0	148,157	50.00
51.00 RECOVERY ROOM	0	0	0	0	51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00 ANESTHESIOLOGY	0	344	0	344	53.00
54.00 RADIOLOGY - DIAGNOSTIC	0	139,421	0	139,421	54.00
56.00 RADIOISOTOPE	0	0	0	0	56.00
57.00 CT SCAN	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00 LABORATORY	0	66,332	0	66,332	60.00
60.01 BLOOD LABORATORY	0	0	0	0	60.01
63.00 BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	63.00
64.00 INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00 RESPIRATORY THERAPY	0	22,438	0	22,438	65.00
66.00 PHYSICAL THERAPY	0	92,666	0	92,666	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	0	10,189	0	10,189	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	25,052	0	25,052	71.00
72.00 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	333	0	333	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	33,127	0	33,127	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00 CLINIC	0	0	0	0	90.00
91.00 EMERGENCY	0	88,062	0	88,062	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)			0		92.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	1,018,404	0	1,018,404	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	10,131	0	10,131	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00 OTHER NRCC - PHYSICIAN CLINIC	0	114,591	0	114,591	194.00
194.01 OTHER NRCC - JAIL	0	849	0	849	194.01
194.02 OTHER NRCC - PUBLIC RELATIONS	0	9,150	0	9,150	194.02
194.03 OTHER NRCC - DR. OFFICE	0	57,790	0	57,790	194.03
200.00 Cross Foot Adjustments	0	0	0	0	200.00
201.00 Negative Cost Centers	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	0	1,210,915	0	1,210,915	202.00

Cost Center Description	CAPITAL RELATED COSTS					
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS (GROSS SALARIES)	NONPATIENT TELEPHONES (NONPATIENT PHONES)	PURCHASING RECEIVING AND STORES (COST OF SUPPLIES)	
	1.00	2.00	4.00	5.01	5.02	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	CAP REL COSTS-BLDG & FIXT	73,699				1.00
2.00	CAP REL COSTS-MVBLE EQUIP		73,699			2.00
4.00	EMPLOYEE BENEFITS	1,113	1,113	6,218,174		4.00
5.01	NONPATIENT TELEPHONES	311	311	29,969	239	5.01
5.02	PURCHASING RECEIVING AND STORES	1,529	1,529	29,434	0	5.02
5.03	CASHIERING/ACCOUNTS RECEIVABLE	1,984	1,984	334,967	26	5.03
5.04	OTHER ADMINISTRATIVE AND GENERAL	4,865	4,865	585,892	47	5.04
6.00	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	OPERATION OF PLANT	5,632	5,632	128,920	10	7.00
8.00	LAUNDRY & LINEN SERVICE	241	241	16,526	2	8.00
9.00	HOUSEKEEPING	860	860	136,427	1	9.00
10.00	DIETARY	3,819	3,819	219,162	4	10.00
11.00	CAFETERIA	521	521	0	1	11.00
12.00	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	NURSING ADMINISTRATION	0	0	0	2	13.00
14.00	CENTRAL SERVICES & SUPPLY	1,063	1,063	0	1	14.00
15.00	PHARMACY	1,237	1,237	57,682	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	2,142	2,142	111,590	17	16.00
17.00	SOCIAL SERVICE	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	ADULTS & PEDIATRICS	7,587	7,587	1,033,690	14	30.00
31.00	INTENSIVE CARE UNIT	0	0	0	0	31.00
40.00	SUBPROVIDER - IPF	5,963	5,963	739,970	11	40.00
41.00	SUBPROVIDER - IRF	0	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	0	42.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	OPERATING ROOM	7,633	7,633	146,484	14	50.00
51.00	RECOVERY ROOM	0	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	RADIOLOGY - DIAGNOSTIC	5,824	5,824	550,471	16	54.00
56.00	RADIOISOTOPE	0	0	0	0	56.00
57.00	CT SCAN	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	LABORATORY	2,366	2,366	426,162	10	60.00
60.01	BLOOD LABORATORY	0	0	0	0	60.01
63.00	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	63.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	993	993	108,733	6	65.00
66.00	PHYSICAL THERAPY	4,605	4,605	212,049	9	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	423	423	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	5	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	CLINIC	0	0	0	0	90.00
91.00	EMERGENCY	2,766	2,766	1,294,691	9	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1-117)	63,477	63,477	6,162,819	205	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	550	550	0	1	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00	OTHER NRCC - PHYSICIAN CLINIC	6,080	6,080	55,355	33	194.00
194.01	OTHER NRCC - JAIL	0	0	0	0	194.01
194.02	OTHER NRCC - PUBLIC RELATIONS	485	485	0	0	194.02
194.03	OTHER NRCC - DR. OFFICE	3,107	3,107	0	0	194.03
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per wkst. B, Part I)	1,007,455	203,460	1,848,862	71,047	202.00
203.00	Unit cost multiplier (wkst. B, Part I)	13.669860	2.760689	0.297332	297.267782	1.122158
204.00	Cost to be allocated (per wkst. B, Part II)			18,288	5,198	25,209
205.00	Unit cost multiplier (wkst. B, Part II)			0.002941	21.748954	0.332485

Cost Center Description	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (DOLLAR VALUE)	OPERATION OF PLANT (SQUARE FEET)	
	5.03	5A.04	5.04	6.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 CAP REL COSTS-BLDG & FIXT						1.00
2.00 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 EMPLOYEE BENEFITS						4.00
5.01 NONPATIENT TELEPHONES						5.01
5.02 PURCHASING RECEIVING AND STORES						5.02
5.03 CASHIERING/ACCOUNTS RECEIVABLE	33,642,201					5.03
5.04 OTHER ADMINISTRATIVE AND GENERAL	0	-2,814,293	12,015,800			5.04
6.00 MAINTENANCE & REPAIRS	0	0	0	0		6.00
7.00 OPERATION OF PLANT	0	0	861,386	0	58,265	7.00
8.00 LAUNDRY & LINEN SERVICE	0	0	60,569	0	241	8.00
9.00 HOUSEKEEPING	0	0	211,419	0	860	9.00
10.00 DIETARY	0	0	328,913	0	3,819	10.00
11.00 CAFETERIA	0	0	39,778	0	521	11.00
12.00 MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00 NURSING ADMINISTRATION	0	0	84,285	0	0	13.00
14.00 CENTRAL SERVICES & SUPPLY	0	0	17,763	0	1,063	14.00
15.00 PHARMACY	0	0	215,745	0	1,237	15.00
16.00 MEDICAL RECORDS & LIBRARY	0	0	241,185	0	2,142	16.00
17.00 SOCIAL SERVICE	0	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 ADULTS & PEDIATRICS	3,040,527	0	1,617,421	0	7,587	30.00
31.00 INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00 SUBPROVIDER - IPF	4,072,800	0	1,583,949	0	5,963	40.00
41.00 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00 SUBPROVIDER	0	0	0	0	0	42.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 OPERATING ROOM	1,441,124	0	420,433	0	7,633	50.00
51.00 RECOVERY ROOM	0	0	0	0	0	51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 ANESTHESIOLOGY	92,670	0	8,060	0	0	53.00
54.00 RADIOLOGY - DIAGNOSTIC	7,648,780	0	1,407,141	0	5,824	54.00
56.00 RADIOISOTOPE	0	0	0	0	0	56.00
57.00 CT SCAN	0	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 LABORATORY	3,910,871	0	1,166,271	0	2,366	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
63.00 BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	63.00
64.00 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 RESPIRATORY THERAPY	712,835	0	184,005	0	993	65.00
66.00 PHYSICAL THERAPY	1,498,900	0	381,673	0	4,605	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	985,764	0	32,172	0	423	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	1,768,719	0	212,180	0	0	71.00
72.00 IMPLANTABLE DEVICES CHARGED TO PATIENTS	79,214	0	21,916	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	2,888,517	0	441,170	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 CLINIC	0	0	0	0	0	90.00
91.00 EMERGENCY	5,501,480	0	2,117,607	0	2,766	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00 SUBTOTALS (SUM OF LINES 1-117)	33,642,201	-2,814,293	11,655,041	0	48,043	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	9,333	0	550	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00 OTHER NRCC - PHYSICIAN CLINIC	0	0	195,367	0	6,080	194.00
194.01 OTHER NRCC - JAIL	0	0	96,655	0	0	194.01
194.02 OTHER NRCC - PUBLIC RELATIONS	0	0	8,355	0	485	194.02
194.03 OTHER NRCC - DR. OFFICE	0	0	51,049	0	3,107	194.03
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per wkst. B, Part I)	689,847		2,814,293	0	1,063,136	202.00
203.00 Unit cost multiplier (wkst. B, Part I)	0.020505		0.234216	0.000000	18.246563	203.00
204.00 Cost to be allocated (per wkst. B, Part II)	34,193		84,037	0	105,258	204.00
205.00 Unit cost multiplier (wkst. B, Part II)	0.001016		0.006994	0.000000	1.806539	205.00

Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MANHOURS)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	
	8.00	9.00	10.00	11.00	12.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00						1.00
2.00						2.00
4.00						4.00
5.01						5.01
5.02						5.02
5.03						5.03
5.04						5.04
6.00						6.00
7.00						7.00
8.00	16,283					8.00
9.00	803	49,186				9.00
10.00	0	0	35,850			10.00
11.00	0	455	0	183,986		11.00
12.00	0	0	0	0	0	12.00
13.00	0	0	0	0	0	13.00
14.00	0	0	0	0	0	14.00
15.00	0	275	0	1,793	0	15.00
16.00	0	1,632	0	8,274	0	16.00
17.00	0	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	6,203	14,593	26,082	53,356	0	30.00
31.00	0	0	0	0	0	31.00
40.00	2,960	11,041	9,768	37,539	0	40.00
41.00	0	0	0	0	0	41.00
42.00	0	0	0	0	0	42.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	959	625	0	8,310	0	50.00
51.00	0	0	0	0	0	51.00
52.00	0	0	0	0	0	52.00
53.00	0	0	0	0	0	53.00
54.00	1,098	3,365	0	16,364	0	54.00
56.00	0	0	0	0	0	56.00
57.00	0	0	0	0	0	57.00
58.00	0	0	0	0	0	58.00
59.00	0	0	0	0	0	59.00
60.00	84	2,970	0	22,395	0	60.00
60.01	0	0	0	0	0	60.01
63.00	0	0	0	0	0	63.00
64.00	0	0	0	0	0	64.00
65.00	0	1,550	0	4,906	0	65.00
66.00	802	1,325	0	8,046	0	66.00
67.00	0	0	0	0	0	67.00
68.00	0	0	0	0	0	68.00
69.00	0	0	0	0	0	69.00
70.00	0	0	0	0	0	70.00
71.00	0	0	0	0	0	71.00
72.00	0	0	0	0	0	72.00
73.00	0	0	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	0	0	0	0	0	90.00
91.00	3,202	5,640	0	23,003	0	91.00
92.00						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	16,111	43,471	35,850	183,986	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00	0	35	0	0	0	190.00
192.00	0	0	0	0	0	192.00
194.00	172	3,290	0	0	0	194.00
194.01	0	0	0	0	0	194.01
194.02	0	485	0	0	0	194.02
194.03	0	1,905	0	0	0	194.03
200.00						200.00
201.00						201.00
202.00	79,152	280,532	475,634	61,196	0	202.00
203.00	4.861021	5.703493	13.267336	0.332612	0.000000	203.00
204.00	5,337	19,896	75,495	9,985	0	204.00
205.00	0.327765	0.404505	2.105858	0.054270	0.000000	205.00

Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	
	(MANHOURS)	(COSTED REQUIS.)				
	13.00	14.00	15.00	16.00	17.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 CAP REL COSTS-BLDG & FIXT						1.00
2.00 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 EMPLOYEE BENEFITS						4.00
5.01 NONPATIENT TELEPHONES						5.01
5.02 PURCHASING RECEIVING AND STORES						5.02
5.03 CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04 OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00 MAINTENANCE & REPAIRS						6.00
7.00 OPERATION OF PLANT						7.00
8.00 LAUNDRY & LINEN SERVICE						8.00
9.00 HOUSEKEEPING						9.00
10.00 DIETARY						10.00
11.00 CAFETERIA						11.00
12.00 MAINTENANCE OF PERSONNEL						12.00
13.00 NURSING ADMINISTRATION	173,919					13.00
14.00 CENTRAL SERVICES & SUPPLY	0	100				14.00
15.00 PHARMACY	0	0	399,585			15.00
16.00 MEDICAL RECORDS & LIBRARY	0	0	0	33,642,201		16.00
17.00 SOCIAL SERVICE	0	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 ADULTS & PEDIATRICS	53,356	0	2,149	3,040,527	0	30.00
31.00 INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00 SUBPROVIDER - IPF	37,539	0	0	4,072,800	0	40.00
41.00 SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00 SUBPROVIDER	0	0	0	0	0	42.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 OPERATING ROOM	8,310	0	3,461	1,441,124	0	50.00
51.00 RECOVERY ROOM	0	0	0	0	0	51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 ANESTHESIOLOGY	0	0	986	92,670	0	53.00
54.00 RADIOLOGY - DIAGNOSTIC	16,364	0	12,091	7,648,780	0	54.00
56.00 RADIOISOTOPE	0	0	0	0	0	56.00
57.00 CT SCAN	0	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 LABORATORY	22,395	0	81	3,910,871	0	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
63.00 BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	63.00
64.00 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 RESPIRATORY THERAPY	4,906	0	71	712,835	0	65.00
66.00 PHYSICAL THERAPY	8,046	0	175	1,498,900	0	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	0	0	0	985,764	0	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	100	0	1,768,719	0	71.00
72.00 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	79,214	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	380,455	2,888,517	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 CLINIC	0	0	0	0	0	90.00
91.00 EMERGENCY	23,003	0	116	5,501,480	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00 SUBTOTALS (SUM OF LINES 1-117)	173,919	100	399,585	33,642,201	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00 OTHER NRCC - PHYSICIAN CLINIC	0	0	0	0	0	194.00
194.01 OTHER NRCC - JAIL	0	0	0	0	0	194.01
194.02 OTHER NRCC - PUBLIC RELATIONS	0	0	0	0	0	194.02
194.03 OTHER NRCC - DR. OFFICE	0	0	0	0	0	194.03
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	104,026	41,319	291,011	348,818	0	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	0.598129	413.190000	0.728283	0.010368	0.000000	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	632	19,532	24,513	42,579	0	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)	0.003634	195.320000	0.061346	0.001266	0.000000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151325

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

Worksheet C  
Part I  
Date/Time Prepared:  
1/26/2012 12:42 pm

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Title XVIII		Hospital		Cost
				Total Costs	RCE Disallowance	Total Costs		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	ADULTS & PEDIATRICS	2,676,859		2,676,859	0	2,676,859	30.00	
31.00	INTENSIVE CARE UNIT	0		0	0	0	31.00	
40.00	SUBPROVIDER - IPF	2,347,861		2,347,861	0	2,347,861	40.00	
41.00	SUBPROVIDER - IRF	0		0	0	0	41.00	
42.00	SUBPROVIDER	0		0	0	0	42.00	
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	OPERATING ROOM	691,606		691,606	0	691,606	50.00	
51.00	RECOVERY ROOM	0		0	0	0	51.00	
52.00	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00	
53.00	ANESTHESIOLOGY	11,627		11,627	0	11,627	53.00	
54.00	RADIOLOGY - DIAGNOSTIC	1,970,868		1,970,868	0	1,970,868	54.00	
56.00	RADIOISOTOPE	0		0	0	0	56.00	
57.00	CT SCAN	0		0	0	0	57.00	
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00	
59.00	CARDIAC CATHETERIZATION	0		0	0	0	59.00	
60.00	LABORATORY	1,561,399		1,561,399	0	1,561,399	60.00	
60.01	BLOOD LABORATORY	0		0	0	0	60.01	
63.00	BLOOD STORING, PROCESSING, & TRANS.	0		0	0	0	63.00	
64.00	INTRAVENOUS THERAPY	0		0	0	0	64.00	
65.00	RESPIRATORY THERAPY	266,070	0	266,070	0	266,070	65.00	
66.00	PHYSICAL THERAPY	589,705	0	589,705	0	589,705	66.00	
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00	
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00	
69.00	ELECTROCARDIOLOGY	57,645		57,645	0	57,645	69.00	
70.00	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00	
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	321,533		321,533	0	321,533	71.00	
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	27,870		27,870	0	27,870	72.00	
73.00	DRUGS CHARGED TO PATIENTS	851,526		851,526	0	851,526	73.00	
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	CLINIC	0		0	0	0	90.00	
91.00	EMERGENCY	2,790,322		2,790,322	0	2,790,322	91.00	
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	500,868		500,868	0	500,868	92.00	
200.00	Subtotal (see instructions)	14,665,759	0	14,665,759	0	14,665,759	200.00	
201.00	Less observation beds	500,868		500,868	0	500,868	201.00	
202.00	Total (see instructions)	14,164,891	0	14,164,891	0	14,164,891	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151325

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

Worksheet C  
Part I  
Date/Time Prepared:  
1/26/2012 12:42 pm

		Title XVIII			Hospital	Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				
			9.00	10.00			
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	ADULTS & PEDIATRICS	2,476,619		2,476,619			30.00
31.00	INTENSIVE CARE UNIT	0		0			31.00
40.00	SUBPROVIDER - IPF	4,072,800		4,072,800			40.00
41.00	SUBPROVIDER - IRF	0		0			41.00
42.00	SUBPROVIDER	0		0			42.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM	326,858	1,114,266	1,441,124	0.479907	0.000000	50.00
51.00	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	ANESTHESIOLOGY	27,168	65,502	92,670	0.125467	0.000000	53.00
54.00	RADIOLOGY - DIAGNOSTIC	1,702,903	5,945,877	7,648,780	0.257671	0.000000	54.00
56.00	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
57.00	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	LABORATORY	1,022,119	2,888,752	3,910,871	0.399246	0.000000	60.00
60.01	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
63.00	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0.000000	0.000000	63.00
64.00	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
65.00	RESPIRATORY THERAPY	459,651	253,184	712,835	0.373256	0.000000	65.00
66.00	PHYSICAL THERAPY	672,002	826,898	1,498,900	0.393425	0.000000	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	ELECTROCARDIOLOGY	182,751	803,013	985,764	0.058477	0.000000	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	785,081	983,638	1,768,719	0.181789	0.000000	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	79,214	79,214	0.351832	0.000000	72.00
73.00	DRUGS CHARGED TO PATIENTS	1,852,061	1,036,456	2,888,517	0.294797	0.000000	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	EMERGENCY	2,461,467	3,040,013	5,501,480	0.507195	0.000000	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	563,908	563,908	0.888209	0.000000	92.00
200.00	Subtotal (see instructions)	16,041,480	17,600,721	33,642,201			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	16,041,480	17,600,721	33,642,201			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 151325	Period: From 07/01/2010 To 06/30/2011	Worksheet C Part I Date/Time Prepared: 1/26/2012 12:42 pm
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Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	Cost
		11.00			
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	ADULTS & PEDIATRICS				30.00
31.00	INTENSIVE CARE UNIT				31.00
40.00	SUBPROVIDER - IPF				40.00
41.00	SUBPROVIDER - IRF				41.00
42.00	SUBPROVIDER				42.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	OPERATING ROOM	0.479907			50.00
51.00	RECOVERY ROOM	0.000000			51.00
52.00	DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	ANESTHESIOLOGY	0.125467			53.00
54.00	RADIOLOGY - DIAGNOSTIC	0.257671			54.00
56.00	RADIOISOTOPE	0.000000			56.00
57.00	CT SCAN	0.000000			57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000			58.00
59.00	CARDIAC CATHETERIZATION	0.000000			59.00
60.00	LABORATORY	0.399246			60.00
60.01	BLOOD LABORATORY	0.000000			60.01
63.00	BLOOD STORING, PROCESSING, & TRANS.	0.000000			63.00
64.00	INTRAVENOUS THERAPY	0.000000			64.00
65.00	RESPIRATORY THERAPY	0.373256			65.00
66.00	PHYSICAL THERAPY	0.393425			66.00
67.00	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	SPEECH PATHOLOGY	0.000000			68.00
69.00	ELECTROCARDIOLOGY	0.058477			69.00
70.00	ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.181789			71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.351832			72.00
73.00	DRUGS CHARGED TO PATIENTS	0.294797			73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	CLINIC	0.000000			90.00
91.00	EMERGENCY	0.507195			91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.888209			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: 151325

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

Worksheet C  
Part I  
Date/Time Prepared:  
1/26/2012 12:43 pm

Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Title XIX		Hospital		Total Costs
			Total Costs	RCE Disallowance	Total Costs	Cost	
			1.00	2.00	3.00	4.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	ADULTS & PEDIATRICS	2,676,859		2,676,859	0	0	30.00
31.00	INTENSIVE CARE UNIT	0		0	0	0	31.00
40.00	SUBPROVIDER - IPF	2,347,861		2,347,861	0	0	40.00
41.00	SUBPROVIDER - IRF	0		0	0	0	41.00
42.00	SUBPROVIDER	0		0	0	0	42.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM	691,606		691,606	0	0	50.00
51.00	RECOVERY ROOM	0		0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	ANESTHESIOLOGY	11,627		11,627	0	0	53.00
54.00	RADIOLOGY - DIAGNOSTIC	1,970,868		1,970,868	0	0	54.00
56.00	RADIOISOTOPE	0		0	0	0	56.00
57.00	CT SCAN	0		0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	LABORATORY	1,561,399		1,561,399	0	0	60.00
60.01	BLOOD LABORATORY	0		0	0	0	60.01
63.00	BLOOD STORING, PROCESSING, & TRANS.	0		0	0	0	63.00
64.00	INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	RESPIRATORY THERAPY	266,070	0	266,070	0	0	65.00
66.00	PHYSICAL THERAPY	589,705	0	589,705	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	57,645		57,645	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	321,533		321,533	0	0	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	27,870		27,870	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	851,526		851,526	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	CLINIC	0		0	0	0	90.00
91.00	EMERGENCY	2,790,322		2,790,322	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	500,868		500,868	0	0	92.00
200.00	Subtotal (see instructions)	14,665,759	0	14,665,759	0	0	200.00
201.00	Less Observation Beds	500,868		500,868	0	0	201.00
202.00	Total (see instructions)	14,164,891	0	14,164,891	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES  
 Provider CCN: 151325  
 Period: From 07/01/2010 To 06/30/2011  
 Worksheet C Part I  
 Date/Time Prepared: 1/26/2012 12:43 pm

Cost Center Description	Title XIX			Hospital	Cost		
	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
6.00	7.00	8.00	9.00	10.00			
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	ADULTS & PEDIATRICS	2,476,619		2,476,619			30.00
31.00	INTENSIVE CARE UNIT	0		0			31.00
40.00	SUBPROVIDER - IPF	4,072,800		4,072,800			40.00
41.00	SUBPROVIDER - IRF	0		0			41.00
42.00	SUBPROVIDER	0		0			42.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM	326,858	1,114,266	1,441,124	0.479907	0.000000	50.00
51.00	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	ANESTHESIOLOGY	27,168	65,502	92,670	0.125467	0.000000	53.00
54.00	RADIOLOGY - DIAGNOSTIC	1,702,903	5,945,877	7,648,780	0.257671	0.000000	54.00
56.00	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
57.00	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	LABORATORY	1,022,119	2,888,752	3,910,871	0.399246	0.000000	60.00
60.01	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
63.00	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0.000000	0.000000	63.00
64.00	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
65.00	RESPIRATORY THERAPY	459,651	253,184	712,835	0.373256	0.000000	65.00
66.00	PHYSICAL THERAPY	672,002	826,898	1,498,900	0.393425	0.000000	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	ELECTROCARDIOLOGY	182,751	803,013	985,764	0.058477	0.000000	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	785,081	983,638	1,768,719	0.181789	0.000000	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	79,214	79,214	0.351832	0.000000	72.00
73.00	DRUGS CHARGED TO PATIENTS	1,852,061	1,036,456	2,888,517	0.294797	0.000000	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	EMERGENCY	2,461,467	3,040,013	5,501,480	0.507195	0.000000	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	563,908	563,908	0.888209	0.000000	92.00
200.00	Subtotal (see instructions)	16,041,480	17,600,721	33,642,201			200.00
201.00	Less observation Beds						201.00
202.00	Total (see instructions)	16,041,480	17,600,721	33,642,201			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151325

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

Worksheet C  
Part I  
Date/Time Prepared:  
1/26/2012 12:43 pm

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	ADULTS & PEDIATRICS				30.00
31.00	INTENSIVE CARE UNIT				31.00
40.00	SUBPROVIDER - IPF				40.00
41.00	SUBPROVIDER - IRF				41.00
42.00	SUBPROVIDER				42.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	OPERATING ROOM	0.000000			50.00
51.00	RECOVERY ROOM	0.000000			51.00
52.00	DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	ANESTHESIOLOGY	0.000000			53.00
54.00	RADIOLOGY - DIAGNOSTIC	0.000000			54.00
56.00	RADIOISOTOPE	0.000000			56.00
57.00	CT SCAN	0.000000			57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000			58.00
59.00	CARDIAC CATHETERIZATION	0.000000			59.00
60.00	LABORATORY	0.000000			60.00
60.01	BLOOD LABORATORY	0.000000			60.01
63.00	BLOOD STORING, PROCESSING, & TRANS.	0.000000			63.00
64.00	INTRAVENOUS THERAPY	0.000000			64.00
65.00	RESPIRATORY THERAPY	0.000000			65.00
66.00	PHYSICAL THERAPY	0.000000			66.00
67.00	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	SPEECH PATHOLOGY	0.000000			68.00
69.00	ELECTROCARDIOLOGY	0.000000			69.00
70.00	ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000			72.00
73.00	DRUGS CHARGED TO PATIENTS	0.000000			73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	CLINIC	0.000000			90.00
91.00	EMERGENCY	0.000000			91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
200.00	Subtotal (see instructions)				200.00
201.00	Less observation Beds				201.00
202.00	Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 151325	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part II Date/Time Prepared: 1/26/2012 12:42 pm
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Cost Center Description		Title XVIII			Hospital	Cost	
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM	148,157	1,441,124	0.102807	44,630	4,588	50.00
51.00	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	ANESTHESIOLOGY	344	92,670	0.003712	4,320	16	53.00
54.00	RADIOLOGY - DIAGNOSTIC	139,421	7,648,780	0.018228	219,714	4,005	54.00
56.00	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	CT SCAN	0	0	0.000000	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	LABORATORY	66,332	3,910,871	0.016961	239,342	4,059	60.00
60.01	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	BLOOD STORING, PROCESSING, & TRANS.	0	0	0.000000	0	0	63.00
64.00	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	RESPIRATORY THERAPY	22,438	712,835	0.031477	211,358	6,653	65.00
66.00	PHYSICAL THERAPY	92,666	1,498,900	0.061823	58,535	3,619	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	ELECTROCARDIOLOGY	10,189	985,764	0.010336	74,431	769	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	25,052	1,768,719	0.014164	304,484	4,313	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	333	79,214	0.004204	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	33,127	2,888,517	0.011469	546,842	6,272	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	CLINIC	0	0	0.000000	0	0	90.00
91.00	EMERGENCY	88,062	5,501,480	0.016007	2,772	44	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	563,908	0.000000	0	0	92.00
200.00	Total (lines 50-199)	626,121	27,092,782		1,706,428	34,338	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151325

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

Worksheet D  
Part IV  
Date/Time Prepared:  
1/26/2012 12:42 pm

Cost Center Description	Title XVIII			Hospital	Cost	
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
	1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 OPERATING ROOM	0	0	0	0	0	50.00
51.00 RECOVERY ROOM	0	0	0	0	0	51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 RADIOLOGY - DIAGNOSTIC	0	0	0	0	0	54.00
56.00 RADIOISOTOPE	0	0	0	0	0	56.00
57.00 CT SCAN	0	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 LABORATORY	0	0	0	0	0	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
63.00 BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	63.00
64.00 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 CLINIC	0	0	0	0	0	90.00
91.00 EMERGENCY	0	0	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00 Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151325	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part IV Date/Time Prepared: 1/26/2012 12:42 pm
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Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Title XVIII		Hospital		Inpatient Program Charges	Cost
		Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)			
	6.00	7.00	8.00	9.00	10.00		
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM	0	1,441,124	0.000000	0.000000	44,630	50.00
51.00	RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0	52.00
53.00	ANESTHESIOLOGY	0	92,670	0.000000	0.000000	4,320	53.00
54.00	RADIOLOGY - DIAGNOSTIC	0	7,648,780	0.000000	0.000000	219,714	54.00
56.00	RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
57.00	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	LABORATORY	0	3,910,871	0.000000	0.000000	239,342	60.00
60.01	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
63.00	BLOOD STORING, PROCESSING, & TRANS.	0	0	0.000000	0.000000	0	63.00
64.00	INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0	64.00
65.00	RESPIRATORY THERAPY	0	712,835	0.000000	0.000000	211,358	65.00
66.00	PHYSICAL THERAPY	0	1,498,900	0.000000	0.000000	58,535	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	ELECTROCARDIOLOGY	0	985,764	0.000000	0.000000	74,431	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,768,719	0.000000	0.000000	304,484	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	79,214	0.000000	0.000000	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	2,888,517	0.000000	0.000000	546,842	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	EMERGENCY	0	5,501,480	0.000000	0.000000	2,772	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	563,908	0.000000	0.000000	0	92.00
200.00	Total (lines 50-199)	0	27,092,782			1,706,428	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151325

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

Worksheet D  
Part IV  
Date/Time Prepared:  
1/26/2012 12:42 pm

Cost Center Description	Title XVIII			Hospital	Cost		
	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School		
	11.00	12.00	13.00	21.00	22.00		
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM	0	0	0	0	0	50.00
51.00	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY - DIAGNOSTIC	0	0	0	0	0	54.00
56.00	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	CT SCAN	0	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	0	0	0	0	0	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	63.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	CLINIC	0	0	0	0	0	90.00
91.00	EMERGENCY	0	0	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00	Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151325

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

Worksheet D  
Part IV  
Date/Time Prepared:  
1/26/2012 12:42 pm

Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost		Cost
		23.00	24.00		
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	OPERATING ROOM	0	0		50.00
51.00	RECOVERY ROOM	0	0		51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	ANESTHESIOLOGY	0	0		53.00
54.00	RADIOLOGY - DIAGNOSTIC	0	0		54.00
56.00	RADIOISOTOPE	0	0		56.00
57.00	CT SCAN	0	0		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	CARDIAC CATHETERIZATION	0	0		59.00
60.00	LABORATORY	0	0		60.00
60.01	BLOOD LABORATORY	0	0		60.01
63.00	BLOOD STORING, PROCESSING, & TRANS.	0	0		63.00
64.00	INTRAVENOUS THERAPY	0	0		64.00
65.00	RESPIRATORY THERAPY	0	0		65.00
66.00	PHYSICAL THERAPY	0	0		66.00
67.00	OCCUPATIONAL THERAPY	0	0		67.00
68.00	SPEECH PATHOLOGY	0	0		68.00
69.00	ELECTROCARDIOLOGY	0	0		69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0		73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	CLINIC	0	0		90.00
91.00	EMERGENCY	0	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00	Total (lines 50-199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151325	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part V Date/Time Prepared: 1/26/2012 12:42 pm
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Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Cost	
		PPS Reimbursed Services (see instructions)	Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)		
		1.00	2.00	3.00		4.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	OPERATING ROOM	0.479907	0	374,050	0	50.00
51.00	RECOVERY ROOM	0.000000	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	52.00
53.00	ANESTHESIOLOGY	0.125467	0	20,352	0	53.00
54.00	RADIOLOGY - DIAGNOSTIC	0.257671	0	1,814,312	0	54.00
56.00	RADIOISOTOPE	0.000000	0	0	0	56.00
57.00	CT SCAN	0.000000	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0.000000	0	0	0	59.00
60.00	LABORATORY	0.399246	0	1,013,575	0	60.00
60.01	BLOOD LABORATORY	0.000000	0	0	0	60.01
63.00	BLOOD STORING, PROCESSING, & TRANS.	0.000000	0	0	0	63.00
64.00	INTRAVENOUS THERAPY	0.000000	0	0	0	64.00
65.00	RESPIRATORY THERAPY	0.373256	0	205,712	0	65.00
66.00	PHYSICAL THERAPY	0.393425	0	242,375	0	66.00
67.00	OCCUPATIONAL THERAPY	0.000000	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0.000000	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0.058477	0	320,507	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.181789	0	254,675	0	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.351832	0	41,897	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.294797	0	319,328	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	CLINIC	0.000000	0	0	0	90.00
91.00	EMERGENCY	0.507195	0	1,006,637	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.888209	0	104,962	0	92.00
200.00	Subtotal (see instructions)		0	5,718,382	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		0	5,718,382	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151325	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part V Date/Time Prepared: 1/26/2012 12:42 pm
Title XVIII		Hospital	Cost

Cost Center Description	Costs			Hospital	Cost
	PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)		
	5.00	6.00	7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	OPERATING ROOM	0	179,509	0	50.00
51.00	RECOVERY ROOM	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	ANESTHESIOLOGY	0	2,554	0	53.00
54.00	RADIOLOGY - DIAGNOSTIC	0	467,496	0	54.00
56.00	RADIOISOTOPE	0	0	0	56.00
57.00	CT SCAN	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	LABORATORY	0	404,666	0	60.00
60.01	BLOOD LABORATORY	0	0	0	60.01
63.00	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	63.00
64.00	INTRAVENOUS THERAPY	0	0	0	64.00
65.00	RESPIRATORY THERAPY	0	76,783	0	65.00
66.00	PHYSICAL THERAPY	0	95,356	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	18,742	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	46,297	0	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	14,741	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	94,137	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	CLINIC	0	0	0	90.00
91.00	EMERGENCY	0	510,561	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	93,228	0	92.00
200.00	Subtotal (see instructions)	0	2,004,070	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges		0		201.00
202.00	Net Charges (line 200 +/- line 201)	0	2,004,070	0	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 151325 Component CCN: 15M325	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part II Date/Time Prepared: 1/26/2012 12:42 pm
	Title XVIII	Subprovider - IPF	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	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 OPERATING ROOM	148,157	1,441,124	0.102807	0	0	50.00
51.00 RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00 ANESTHESIOLOGY	344	92,670	0.003712	0	0	53.00
54.00 RADIOLOGY - DIAGNOSTIC	139,421	7,648,780	0.018228	45,726	833	54.00
56.00 RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00 CT SCAN	0	0	0.000000	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00 LABORATORY	66,332	3,910,871	0.016961	141,521	2,400	60.00
60.01 BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00 BLOOD STORING, PROCESSING, & TRANS.	0	0	0.000000	0	0	63.00
64.00 INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00 RESPIRATORY THERAPY	22,438	712,835	0.031477	9,288	292	65.00
66.00 PHYSICAL THERAPY	92,666	1,498,900	0.061823	45,394	2,806	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00 ELECTROCARDIOLOGY	10,189	985,764	0.010336	41,496	429	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	25,052	1,768,719	0.014164	58,370	827	71.00
72.00 IMPLANTABLE DEVICES CHARGED TO PATIENTS	333	79,214	0.004204	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	33,127	2,888,517	0.011469	386,237	4,430	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 CLINIC	0	0	0.000000	0	0	90.00
91.00 EMERGENCY	88,062	5,501,480	0.016007	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	563,908	0.000000	0	0	92.00
200.00 Total (lines 50-199)	626,121	27,092,782		728,032	12,017	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151325 Component CCN:15M325	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part IV Date/Time Prepared: 1/26/2012 12:42 pm
	Title XVIII	Subprovider - IPF	PPS

Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
	1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 OPERATING ROOM	0	0	0	0	0	50.00
51.00 RECOVERY ROOM	0	0	0	0	0	51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 RADIOLOGY - DIAGNOSTIC	0	0	0	0	0	54.00
56.00 RADIOISOTOPE	0	0	0	0	0	56.00
57.00 CT SCAN	0	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 LABORATORY	0	0	0	0	0	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
63.00 BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	63.00
64.00 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 CLINIC	0	0	0	0	0	90.00
91.00 EMERGENCY	0	0	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00 Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151325  
Component CCN: 15M325

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

Worksheet D  
Part IV  
Date/Time Prepared:  
1/26/2012 12:42 pm

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM	0	1,441,124	0.000000	0.000000	0	50.00
51.00	RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0	52.00
53.00	ANESTHESIOLOGY	0	92,670	0.000000	0.000000	0	53.00
54.00	RADIOLOGY - DIAGNOSTIC	0	7,648,780	0.000000	0.000000	45,726	54.00
56.00	RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
57.00	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	LABORATORY	0	3,910,871	0.000000	0.000000	141,521	60.00
60.01	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
63.00	BLOOD STORING, PROCESSING, & TRANS.	0	0	0.000000	0.000000	0	63.00
64.00	INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0	64.00
65.00	RESPIRATORY THERAPY	0	712,835	0.000000	0.000000	9,288	65.00
66.00	PHYSICAL THERAPY	0	1,498,900	0.000000	0.000000	45,394	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	ELECTROCARDIOLOGY	0	985,764	0.000000	0.000000	41,496	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,768,719	0.000000	0.000000	58,370	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	79,214	0.000000	0.000000	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	2,888,517	0.000000	0.000000	386,237	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	EMERGENCY	0	5,501,480	0.000000	0.000000	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	563,908	0.000000	0.000000	0	92.00
200.00	Total (lines 50-199)	0	27,092,782			728,032	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151325 Component CCN: 15M325	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part IV Date/Time Prepared: 1/26/2012 12:42 pm
Title XVIII		Subprovider - IPF	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)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
	11.00	12.00	13.00	21.00	22.00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 OPERATING ROOM	0	0	0	0	0	50.00
51.00 RECOVERY ROOM	0	0	0	0	0	51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 RADIOLOGY - DIAGNOSTIC	0	0	0	0	0	54.00
56.00 RADIOISOTOPE	0	0	0	0	0	56.00
57.00 CT SCAN	0	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 LABORATORY	0	0	0	0	0	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
63.00 BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	63.00
64.00 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 CLINIC	0	0	0	0	0	90.00
91.00 EMERGENCY	0	0	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00 Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151325 Component CCN: 15M325	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part IV Date/Time Prepared: 1/26/2012 12:42 pm
	Title XVIII	Subprovider - IPF	PPS

Cost Center Description	PSA Adj.	PSA Adj. All		
	Allied Health	Other Medical Education Cost		
	23.00	24.00		
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00 OPERATING ROOM	0	0		50.00
51.00 RECOVERY ROOM	0	0		51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 ANESTHESIOLOGY	0	0		53.00
54.00 RADIOLOGY - DIAGNOSTIC	0	0		54.00
56.00 RADIOISOTOPE	0	0		56.00
57.00 CT SCAN	0	0		57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00 CARDIAC CATHETERIZATION	0	0		59.00
60.00 LABORATORY	0	0		60.00
60.01 BLOOD LABORATORY	0	0		60.01
63.00 BLOOD STORING, PROCESSING, & TRANS.	0	0		63.00
64.00 INTRAVENOUS THERAPY	0	0		64.00
65.00 RESPIRATORY THERAPY	0	0		65.00
66.00 PHYSICAL THERAPY	0	0		66.00
67.00 OCCUPATIONAL THERAPY	0	0		67.00
68.00 SPEECH PATHOLOGY	0	0		68.00
69.00 ELECTROCARDIOLOGY	0	0		69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0		73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00 CLINIC	0	0		90.00
91.00 EMERGENCY	0	0		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00 Total (lines 50-199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151325 Component CCN: 152325	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part V Date/Time Prepared: 1/26/2012 12:42 pm
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Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Swing Beds - SNF	Cost
		PPS Reimbursed Services (see instructions)	Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)		
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	OPERATING ROOM	0.479907	0	0	0	50.00
51.00	RECOVERY ROOM	0.000000	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	52.00
53.00	ANESTHESIOLOGY	0.125467	0	0	0	53.00
54.00	RADIOLOGY - DIAGNOSTIC	0.257671	0	0	0	54.00
56.00	RADIOISOTOPE	0.000000	0	0	0	56.00
57.00	CT SCAN	0.000000	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0.000000	0	0	0	59.00
60.00	LABORATORY	0.399246	0	0	0	60.00
60.01	BLOOD LABORATORY	0.000000	0	0	0	60.01
63.00	BLOOD STORING, PROCESSING, & TRANS.	0.000000	0	0	0	63.00
64.00	INTRAVENOUS THERAPY	0.000000	0	0	0	64.00
65.00	RESPIRATORY THERAPY	0.373256	0	0	0	65.00
66.00	PHYSICAL THERAPY	0.393425	0	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0.000000	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0.000000	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0.058477	0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.181789	0	0	0	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.351832	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.294797	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	CLINIC	0.000000	0	0	0	90.00
91.00	EMERGENCY	0.507195	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.888209	0	0	0	92.00
200.00	Subtotal (see instructions)		0	0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151325 Component CCN: 152325	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part V Date/Time Prepared: 1/26/2012 12:42 pm
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Cost Center Description	Costs			Swing Beds - SNF	Cost
	PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)		
	5.00	6.00	7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	OPERATING ROOM	0	0	0	50.00
51.00	RECOVERY ROOM	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	ANESTHESIOLOGY	0	0	0	53.00
54.00	RADIOLOGY - DIAGNOSTIC	0	0	0	54.00
56.00	RADIOISOTOPE	0	0	0	56.00
57.00	CT SCAN	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	LABORATORY	0	0	0	60.00
60.01	BLOOD LABORATORY	0	0	0	60.01
63.00	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	63.00
64.00	INTRAVENOUS THERAPY	0	0	0	64.00
65.00	RESPIRATORY THERAPY	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	CLINIC	0	0	0	90.00
91.00	EMERGENCY	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
200.00	Subtotal (see instructions)	0	0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges		0		201.00
202.00	Net Charges (line 200 +/- line 201)	0	0	0	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 151325		Period: From 07/01/2010 To 06/30/2011		Worksheet D Part I Date/Time Prepared: 1/26/2012 12:43 pm	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	ADULTS & PEDIATRICS	230,630	78,603	152,027	2,991	50.83	30.00
31.00	INTENSIVE CARE UNIT	0		0	0	0.00	31.00
40.00	SUBPROVIDER - IPF	161,653	0	161,653	3,388	47.71	40.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0.00	41.00
42.00	SUBPROVIDER	0	0	0	0	0.00	42.00
200.00	Total (Lines 30-199)	392,283		313,680	6,379		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS	Provider CCN: 151325	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part I Date/Time Prepared: 1/26/2012 12:43 pm
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Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)		
		6.00	7.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	ADULTS & PEDIATRICS	237	12,047		30.00
31.00	INTENSIVE CARE UNIT	0	0		31.00
40.00	SUBPROVIDER - IPF	0	0		40.00
41.00	SUBPROVIDER - IRF	0	0		41.00
42.00	SUBPROVIDER	0	0		42.00
200.00	Total (lines 30-199)	237	12,047		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 151325	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part II Date/Time Prepared: 1/26/2012 12:43 pm
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Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Title XIX Hospital		Capital Costs (column 3 x column 4)	
				Inpatient Program Charges	Cost		
	1.00	2.00	3.00	4.00	5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM	148,157	1,441,124	0.102807	276,706	28,447	50.00
51.00	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	ANESTHESIOLOGY	344	92,670	0.003712	22,560	84	53.00
54.00	RADIOLOGY - DIAGNOSTIC	139,421	7,648,780	0.018228	1,398,086	25,484	54.00
56.00	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	CT SCAN	0	0	0.000000	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	LABORATORY	66,332	3,910,871	0.016961	548,709	9,307	60.00
60.01	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	BLOOD STORING, PROCESSING, & TRANS.	0	0	0.000000	0	0	63.00
64.00	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	RESPIRATORY THERAPY	22,438	712,835	0.031477	123,496	3,887	65.00
66.00	PHYSICAL THERAPY	92,666	1,498,900	0.061823	57,603	3,561	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	ELECTROCARDIOLOGY	10,189	985,764	0.010336	32,538	336	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	25,052	1,768,719	0.014164	188,048	2,664	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	333	79,214	0.004204	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	33,127	2,888,517	0.011469	288,124	3,304	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	CLINIC	0	0	0.000000	0	0	90.00
91.00	EMERGENCY	88,062	5,501,480	0.016007	2,458,695	39,356	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	563,908	0.000000	0	0	92.00
200.00	Total (lines 50-199)	626,121	27,092,782		5,394,565	116,430	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 151325		Period: From 07/01/2010 To 06/30/2011		Worksheet D Part III Date/Time Prepared: 1/26/2012 12:43 pm		
Cost Center Description		Title XIX			Hospital		Cost	
		Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)		
		1.00	2.00	3.00	4.00	5.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	ADULTS & PEDIATRICS	0	0	0	0	0	0	30.00
31.00	INTENSIVE CARE UNIT	0	0	0	0	0	0	31.00
40.00	SUBPROVIDER - IPF	0	0	0	0	0	0	40.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0	0	41.00
42.00	SUBPROVIDER	0	0	0	0	0	0	42.00
200.00	Total (lines 30-199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151325	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part III Date/Time Prepared: 1/26/2012 12:43 pm
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Cost Center Description	Title XIX Hospital Cost					
	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. Nursing School	
	6.00	7.00	8.00	9.00	11.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 ADULTS & PEDIATRICS	2,991	0.00	237	0	0	30.00
31.00 INTENSIVE CARE UNIT	0	0.00	0	0	0	31.00
40.00 SUBPROVIDER - IPF	3,388	0.00	0	0	0	40.00
41.00 SUBPROVIDER - IRF	0	0.00	0	0	0	41.00
42.00 SUBPROVIDER	0	0.00	0	0	0	42.00
200.00 Total (Lines 30-199)	6,379		237	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151325	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part III Date/Time Prepared: 1/26/2012 12:43 pm
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Cost Center Description	Title XIX		Hospital	Cost
	PSA Adj. Allied Health Cost 12.00	PSA Adj. All Other Medical Education Cost 13.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00 ADULTS & PEDIATRICS	0	0		30.00
31.00 INTENSIVE CARE UNIT	0	0		31.00
40.00 SUBPROVIDER - IPF	0	0		40.00
41.00 SUBPROVIDER - IRF	0	0		41.00
42.00 SUBPROVIDER	0	0		42.00
200.00 Total (lines 30-199)	0	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151325

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

Worksheet D  
Part IV  
Date/Time Prepared:  
1/26/2012 12:43 pm

Cost Center Description	Title XIX				Hospital	Cost	Total Cost (sum of col 1 through col. 4)
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost			
	1.00	2.00	3.00	4.00		5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 OPERATING ROOM	0	0	0	0	0	0	50.00
51.00 RECOVERY ROOM	0	0	0	0	0	0	51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.00
53.00 ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00 RADIOLOGY - DIAGNOSTIC	0	0	0	0	0	0	54.00
56.00 RADIOISOTOPE	0	0	0	0	0	0	56.00
57.00 CT SCAN	0	0	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	0	59.00
60.00 LABORATORY	0	0	0	0	0	0	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	0	60.01
63.00 BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	0	63.00
64.00 INTRAVENOUS THERAPY	0	0	0	0	0	0	64.00
65.00 RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00 PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
72.00 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00 CLINIC	0	0	0	0	0	0	90.00
91.00 EMERGENCY	0	0	0	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00
200.00 Total (lines 50-199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151325

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

Worksheet D  
Part IV  
Date/Time Prepared:  
1/26/2012 12:43 pm

Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Title XIX		Hospital		Inpatient Program Charges	Cost
		Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)			
	6.00	7.00	8.00	9.00	10.00		
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 OPERATING ROOM	0	1,441,124	0.000000	0.000000		276,706	50.00
51.00 RECOVERY ROOM	0	0	0.000000	0.000000		0	51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000		0	52.00
53.00 ANESTHESIOLOGY	0	92,670	0.000000	0.000000		22,560	53.00
54.00 RADIOLOGY - DIAGNOSTIC	0	7,648,780	0.000000	0.000000		1,398,086	54.00
56.00 RADIOISOTOPE	0	0	0.000000	0.000000		0	56.00
57.00 CT SCAN	0	0	0.000000	0.000000		0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000		0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0.000000	0.000000		0	59.00
60.00 LABORATORY	0	3,910,871	0.000000	0.000000		548,709	60.00
60.01 BLOOD LABORATORY	0	0	0.000000	0.000000		0	60.01
63.00 BLOOD STORING, PROCESSING, & TRANS.	0	0	0.000000	0.000000		0	63.00
64.00 INTRAVENOUS THERAPY	0	0	0.000000	0.000000		0	64.00
65.00 RESPIRATORY THERAPY	0	712,835	0.000000	0.000000		123,496	65.00
66.00 PHYSICAL THERAPY	0	1,498,900	0.000000	0.000000		57,603	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0.000000	0.000000		0	67.00
68.00 SPEECH PATHOLOGY	0	0	0.000000	0.000000		0	68.00
69.00 ELECTROCARDIOLOGY	0	985,764	0.000000	0.000000		32,538	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000		0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,768,719	0.000000	0.000000		188,048	71.00
72.00 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	79,214	0.000000	0.000000		0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	2,888,517	0.000000	0.000000		288,124	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00 CLINIC	0	0	0.000000	0.000000		0	90.00
91.00 EMERGENCY	0	5,501,480	0.000000	0.000000		2,458,695	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	563,908	0.000000	0.000000		0	92.00
200.00 Total (lines 50-199)	0	27,092,782				5,394,565	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151325

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

Worksheet D  
Part IV  
Date/Time Prepared:  
1/26/2012 12:43 pm

Cost Center Description	Title XIX			Hospital	Cost		
	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School		
	11.00	12.00	13.00	21.00	22.00		
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM	0	0	0	0	0	50.00
51.00	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY - DIAGNOSTIC	0	0	0	0	0	54.00
56.00	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	CT SCAN	0	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	0	0	0	0	0	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	63.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	CLINIC	0	0	0	0	0	90.00
91.00	EMERGENCY	0	0	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00	Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151325

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

Worksheet D  
Part IV  
Date/Time Prepared:  
1/26/2012 12:43 pm

Cost Center Description		Title XIX		Hospital	Cost
		PSA Adj. Allied Health 23.00	PSA Adj. All Other Medical Education Cost 24.00		
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	OPERATING ROOM	0	0		50.00
51.00	RECOVERY ROOM	0	0		51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	ANESTHESIOLOGY	0	0		53.00
54.00	RADIOLOGY - DIAGNOSTIC	0	0		54.00
56.00	RADIOISOTOPE	0	0		56.00
57.00	CT SCAN	0	0		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	CARDIAC CATHETERIZATION	0	0		59.00
60.00	LABORATORY	0	0		60.00
60.01	BLOOD LABORATORY	0	0		60.01
63.00	BLOOD STORING, PROCESSING, & TRANS.	0	0		63.00
64.00	INTRAVENOUS THERAPY	0	0		64.00
65.00	RESPIRATORY THERAPY	0	0		65.00
66.00	PHYSICAL THERAPY	0	0		66.00
67.00	OCCUPATIONAL THERAPY	0	0		67.00
68.00	SPEECH PATHOLOGY	0	0		68.00
69.00	ELECTROCARDIOLOGY	0	0		69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0		73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	CLINIC	0	0		90.00
91.00	EMERGENCY	0	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00	Total (lines 50-199)	0	0		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 151325 Component CCN: 15M325	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part II Date/Time Prepared: 1/26/2012 12:43 pm
	Title XIX	Subprovider - IPF	Cost

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	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 OPERATING ROOM	148,157	1,441,124	0.102807	0	0	50.00
51.00 RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00 ANESTHESIOLOGY	344	92,670	0.003712	0	0	53.00
54.00 RADIOLOGY - DIAGNOSTIC	139,421	7,648,780	0.018228	0	0	54.00
56.00 RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00 CT SCAN	0	0	0.000000	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00 LABORATORY	66,332	3,910,871	0.016961	0	0	60.00
60.01 BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00 BLOOD STORING, PROCESSING, & TRANS.	0	0	0.000000	0	0	63.00
64.00 INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00 RESPIRATORY THERAPY	22,438	712,835	0.031477	0	0	65.00
66.00 PHYSICAL THERAPY	92,666	1,498,900	0.061823	0	0	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00 ELECTROCARDIOLOGY	10,189	985,764	0.010336	0	0	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	25,052	1,768,719	0.014164	0	0	71.00
72.00 IMPLANTABLE DEVICES CHARGED TO PATIENTS	333	79,214	0.004204	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	33,127	2,888,517	0.011469	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 CLINIC	0	0	0.000000	0	0	90.00
91.00 EMERGENCY	88,062	5,501,480	0.016007	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	563,908	0.000000	0	0	92.00
200.00 Total (lines 50-199)	626,121	27,092,782		0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151325 Component CCN: 15M325	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part IV Date/Time Prepared: 1/26/2012 12:43 pm
Title XIX		Subprovider - IPF	Cost

Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)
	1.00	2.00	3.00	4.00	5.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00 OPERATING ROOM	0	0	0	0	0 50.00
51.00 RECOVERY ROOM	0	0	0	0	0 51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0 52.00
53.00 ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00 RADIOLOGY - DIAGNOSTIC	0	0	0	0	0 54.00
56.00 RADIOISOTOPE	0	0	0	0	0 56.00
57.00 CT SCAN	0	0	0	0	0 57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0 58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0 59.00
60.00 LABORATORY	0	0	0	0	0 60.00
60.01 BLOOD LABORATORY	0	0	0	0	0 60.01
63.00 BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0 63.00
64.00 INTRAVENOUS THERAPY	0	0	0	0	0 64.00
65.00 RESPIRATORY THERAPY	0	0	0	0	0 65.00
66.00 PHYSICAL THERAPY	0	0	0	0	0 66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0	0 67.00
68.00 SPEECH PATHOLOGY	0	0	0	0	0 68.00
69.00 ELECTROCARDIOLOGY	0	0	0	0	0 69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0	0 70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0 71.00
72.00 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00 CLINIC	0	0	0	0	0 90.00
91.00 EMERGENCY	0	0	0	0	0 91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0 92.00
200.00 Total (lines 50-199)	0	0	0	0	0 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151325  
Component CCN: 15M325

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

Worksheet D  
Part IV  
Date/Time Prepared:  
1/26/2012 12:43 pm

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM	0	1,441,124	0.000000	0.000000	0	50.00
51.00	RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0	52.00
53.00	ANESTHESIOLOGY	0	92,670	0.000000	0.000000	0	53.00
54.00	RADIOLOGY - DIAGNOSTIC	0	7,648,780	0.000000	0.000000	0	54.00
56.00	RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
57.00	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	LABORATORY	0	3,910,871	0.000000	0.000000	0	60.00
60.01	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
63.00	BLOOD STORING, PROCESSING, & TRANS.	0	0	0.000000	0.000000	0	63.00
64.00	INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0	64.00
65.00	RESPIRATORY THERAPY	0	712,835	0.000000	0.000000	0	65.00
66.00	PHYSICAL THERAPY	0	1,498,900	0.000000	0.000000	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	ELECTROCARDIOLOGY	0	985,764	0.000000	0.000000	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,768,719	0.000000	0.000000	0	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	79,214	0.000000	0.000000	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	2,888,517	0.000000	0.000000	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	EMERGENCY	0	5,501,480	0.000000	0.000000	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	563,908	0.000000	0.000000	0	92.00
200.00	Total (lines 50-199)	0	27,092,782			0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151325 Component CCN:15M325	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part IV Date/Time Prepared: 1/26/2012 12:43 pm
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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)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM	0	0	0	0	0	50.00
51.00	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY - DIAGNOSTIC	0	0	0	0	0	54.00
56.00	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	CT SCAN	0	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	0	0	0	0	0	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	63.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	CLINIC	0	0	0	0	0	90.00
91.00	EMERGENCY	0	0	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00	Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151325 Component CCN: 15M325	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part IV Date/Time Prepared: 1/26/2012 12:43 pm
	Title XIX	Subprovider - IPF	Cost

Cost Center Description	PSA Adj.	PSA Adj. All		
	Allied Health	Other Medical Education Cost		
	23.00	24.00		
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00 OPERATING ROOM	0	0		50.00
51.00 RECOVERY ROOM	0	0		51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 ANESTHESIOLOGY	0	0		53.00
54.00 RADIOLOGY - DIAGNOSTIC	0	0		54.00
56.00 RADIOISOTOPE	0	0		56.00
57.00 CT SCAN	0	0		57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00 CARDIAC CATHETERIZATION	0	0		59.00
60.00 LABORATORY	0	0		60.00
60.01 BLOOD LABORATORY	0	0		60.01
63.00 BLOOD STORING, PROCESSING, & TRANS.	0	0		63.00
64.00 INTRAVENOUS THERAPY	0	0		64.00
65.00 RESPIRATORY THERAPY	0	0		65.00
66.00 PHYSICAL THERAPY	0	0		66.00
67.00 OCCUPATIONAL THERAPY	0	0		67.00
68.00 SPEECH PATHOLOGY	0	0		68.00
69.00 ELECTROCARDIOLOGY	0	0		69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0		73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00 CLINIC	0	0		90.00
91.00 EMERGENCY	0	0		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00 Total (lines 50-199)	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 151325	Period: From 07/01/2010 To 06/30/2011	Worksheet D-1 Date/Time Prepared: 1/26/2012 12:42 pm
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Cost Center Description	Title XVIII	Hospital	Cost	
			1.00	
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		5,055	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,991	2.00
3.00	Private room days (excluding swing-bed and observation bed days)		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		2,991	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		685	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)		686	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		346	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)		347	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		1,277	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)		685	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)		686	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
<b>SWING BED ADJUSTMENT</b>				
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		149.35	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		149.35	20.00
21.00	Total general inpatient routine service cost (see instructions)		2,676,859	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)		51,675	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)		51,824	25.00
26.00	Total swing-bed cost (see instructions)		912,320	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		1,764,539	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed charges)		2,694,891	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		2,694,891	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.654772	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)		901.00	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)		1,764,539	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		589.95	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		753,366	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)		753,366	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151325

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

Worksheet D-1

Date/Time Prepared:  
1/26/2012 12:42 pm

Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	Cost
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
<b>Intensive Care Type Inpatient Hospital Units</b>							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
<b>Cost Center Description</b>							
						1.00	
48.00	Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					498,368	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,251,734	49.00
<b>PASS THROUGH COST ADJUSTMENTS</b>							
50.00	Pass through costs applicable to Program inpatient routine services (from wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
<b>TARGET AMOUNT AND LIMIT COMPUTATION</b>							
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
<b>PROGRAM INPATIENT ROUTINE SWING BED COST</b>							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					404,116	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					404,706	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					808,822	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
<b>PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY</b>							
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
<b>PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>							
87.00	Total observation bed days (see instructions)					849	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					589.95	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					500,868	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 151325	Period: From 07/01/2010 To 06/30/2011	Worksheet D-1 Date/Time Prepared: 1/26/2012 12:42 pm
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Cost Center Description	Title XVIII		Hospital		Cost	
	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	
<b>COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>						
90.00	Capital-related cost	0	0	0.000000	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	91.00
92.00	Allied health cost	0	0	0.000000	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 151325 Component CCN: 15M325	Period: From 07/01/2010 To 06/30/2011	Worksheet D-1 Date/Time Prepared: 1/26/2012 12:42 pm
	Title XVIII	Subprovider - IPF	PPS

Cost Center Description		1.00	
<b>PART I - ALL PROVIDER COMPONENTS</b>			
<b>INPATIENT DAYS</b>			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,388	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,388	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)	3,388	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)	2,865	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
<b>SWING BED ADJUSTMENT</b>			
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	149.35	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	149.35	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,347,861	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)	2,347,861	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>			
28.00	General inpatient routine service charges (excluding swing-bed charges)	4,072,800	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	4,072,800	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.576473	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	1,202.13	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,347,861	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>			
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>			
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	692.99	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,985,416	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,985,416	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151325 Component CCN: 15M325		Period: From 07/01/2010 To 06/30/2011		Worksheet D-1 Date/Time Prepared: 1/26/2012 12:42 pm	
Title XVIII		Subprovider - IPF		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
<b>Intensive Care Type Inpatient Hospital Units</b>							
43.00	0	0	0.00	0	0		
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
<b>Cost Center Description</b>							
48.00	Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					216,510	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,201,926	49.00
<b>PASS THROUGH COST ADJUSTMENTS</b>							
50.00	Pass through costs applicable to Program inpatient routine services (from wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from wkst. D, sum of Parts II and IV)					12,017	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					12,017	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					2,189,909	53.00
<b>TARGET AMOUNT AND LIMIT COMPUTATION</b>							
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
<b>PROGRAM INPATIENT ROUTINE SWING BED COST</b>							
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
<b>PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY</b>							
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
<b>PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151325	Period: From 07/01/2010 To 06/30/2011	Worksheet D-1
		Component CCN: 15M325		Date/Time Prepared: 1/26/2012 12:42 pm
Title XVIII			Subprovider - IPF	PPS

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
<b>COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>					
90.00 Capital-related cost	0	2,347,861	0.000000	0	0 90.00
91.00 Nursing School cost	0	2,347,861	0.000000	0	0 91.00
92.00 Allied health cost	0	2,347,861	0.000000	0	0 92.00
93.00 All other Medical Education	0	2,347,861	0.000000	0	0 93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 151325	Period: From 07/01/2010 To 06/30/2011	Worksheet D-1 Date/Time Prepared: 1/26/2012 12:43 pm
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Cost Center Description	Title XIX	Hospital	Cost	
				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		5,055	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,991	2.00
3.00	Private room days (excluding swing-bed and observation bed days)		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		2,991	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		685	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)		686	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		346	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)		347	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		237	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
<b>SWING BED ADJUSTMENT</b>				
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		149.35	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		149.35	20.00
21.00	Total general inpatient routine service cost (see instructions)		2,676,859	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)		51,675	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)		51,824	25.00
26.00	Total swing-bed cost (see instructions)		912,320	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		1,764,539	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed charges)		2,694,891	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		2,694,891	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.654772	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)		901.00	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)		1,764,539	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		589.95	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		139,818	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)		139,818	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151325

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

Worksheet D-1

Date/Time Prepared:  
1/26/2012 12:43 pm

		Title XIX			Hospital	Cost	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)					42.00	
<b>Intensive Care Type Inpatient Hospital Units</b>							
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)					2,151,762	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,291,580	49.00
<b>PASS THROUGH COST ADJUSTMENTS</b>							
50.00	Pass through costs applicable to Program inpatient routine services (from wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
<b>TARGET AMOUNT AND LIMIT COMPUTATION</b>							
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
<b>PROGRAM INPATIENT ROUTINE SWING BED COST</b>							
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
<b>PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY</b>							
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
<b>PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>							
87.00	Total observation bed days (see instructions)					849	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					589.95	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					500,868	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 151325	Period: From 07/01/2010 To 06/30/2011	Worksheet D-1 Date/Time Prepared: 1/26/2012 12:43 pm
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Cost Center Description	Cost	Title XIX		Hospital	Cost	
		Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
	1.00	2.00	3.00	4.00	5.00	
<b>COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>						
90.00	Capital-related cost	0	0	0.000000	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	91.00
92.00	Allied health cost	0	0	0.000000	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151325	Period: From 07/01/2010 To 06/30/2011	Worksheet D-3
		Title XVIII	Hospital	Cost
Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
	1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	ADULTS & PEDIATRICS		839,818	30.00
31.00	INTENSIVE CARE UNIT		0	31.00
40.00	SUBPROVIDER - IPF		0	40.00
41.00	SUBPROVIDER - IRF		0	41.00
42.00	SUBPROVIDER		0	42.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	OPERATING ROOM	0.479907	44,630	21,418
51.00	RECOVERY ROOM	0.000000	0	0
52.00	DELIVERY ROOM & LABOR ROOM	0.000000	0	0
53.00	ANESTHESIOLOGY	0.125467	4,320	542
54.00	RADIOLOGY - DIAGNOSTIC	0.257671	219,714	56,614
56.00	RADIOISOTOPE	0.000000	0	0
57.00	CT SCAN	0.000000	0	0
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0
59.00	CARDIAC CATHETERIZATION	0.000000	0	0
60.00	LABORATORY	0.399246	239,342	95,556
60.01	BLOOD LABORATORY	0.000000	0	0
63.00	BLOOD STORING, PROCESSING, & TRANS.	0.000000	0	0
64.00	INTRAVENOUS THERAPY	0.000000	0	0
65.00	RESPIRATORY THERAPY	0.373256	211,358	78,891
66.00	PHYSICAL THERAPY	0.393425	58,535	23,029
67.00	OCCUPATIONAL THERAPY	0.000000	0	0
68.00	SPEECH PATHOLOGY	0.000000	0	0
69.00	ELECTROCARDIOLOGY	0.058477	74,431	4,353
70.00	ELECTROENCEPHALOGRAPHY	0.000000	0	0
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.181789	304,484	55,352
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.351832	0	0
73.00	DRUGS CHARGED TO PATIENTS	0.294797	546,842	161,207
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	CLINIC	0.000000	0	0
91.00	EMERGENCY	0.507195	2,772	1,406
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.888209	0	0
200.00	Total (sum of lines 50-94 and 96-98)		1,706,428	498,368
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0
202.00	Net Charges (line 200 minus line 201)		1,706,428	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151325 Component CCN: 15M325	Period: From 07/01/2010 To 06/30/2011	Worksheet D-3 Date/Time Prepared: 1/26/2012 12:42 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
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	ADULTS & PEDIATRICS		0	30.00
31.00	INTENSIVE CARE UNIT		0	31.00
40.00	SUBPROVIDER - IPF		3,437,695	40.00
41.00	SUBPROVIDER - IRF		0	41.00
42.00	SUBPROVIDER		0	42.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	OPERATING ROOM	0.479907	0	50.00
51.00	RECOVERY ROOM	0.000000	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0.000000	0	52.00
53.00	ANESTHESIOLOGY	0.125467	0	53.00
54.00	RADIOLOGY - DIAGNOSTIC	0.257671	45,726	54.00
56.00	RADIOISOTOPE	0.000000	0	56.00
57.00	CT SCAN	0.000000	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	58.00
59.00	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	LABORATORY	0.399246	141,521	60.00
60.01	BLOOD LABORATORY	0.000000	0	60.01
63.00	BLOOD STORING, PROCESSING, & TRANS.	0.000000	0	63.00
64.00	INTRAVENOUS THERAPY	0.000000	0	64.00
65.00	RESPIRATORY THERAPY	0.373256	9,288	65.00
66.00	PHYSICAL THERAPY	0.393425	45,394	66.00
67.00	OCCUPATIONAL THERAPY	0.000000	0	67.00
68.00	SPEECH PATHOLOGY	0.000000	0	68.00
69.00	ELECTROCARDIOLOGY	0.058477	41,496	69.00
70.00	ELECTROENCEPHALOGRAPHY	0.000000	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.181789	58,370	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.351832	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.294797	386,237	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	CLINIC	0.000000	0	90.00
91.00	EMERGENCY	0.507195	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.888209	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		728,032	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00	Net Charges (line 200 minus line 201)		728,032	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151325 Component CCN: 152325	Period: From 07/01/2010 To 06/30/2011	Worksheet D-3 Date/Time Prepared: 1/26/2012 12:42 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
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	ADULTS & PEDIATRICS		822,600	30.00
31.00	INTENSIVE CARE UNIT		0	31.00
40.00	SUBPROVIDER - IPF		0	40.00
41.00	SUBPROVIDER - IRF		0	41.00
42.00	SUBPROVIDER		0	42.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	OPERATING ROOM	0.479907	5,522	2,650
51.00	RECOVERY ROOM	0.000000	0	0
52.00	DELIVERY ROOM & LABOR ROOM	0.000000	0	0
53.00	ANESTHESIOLOGY	0.125467	288	36
54.00	RADIOLOGY - DIAGNOSTIC	0.257671	39,377	10,146
56.00	RADIOISOTOPE	0.000000	0	0
57.00	CT SCAN	0.000000	0	0
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0
59.00	CARDIAC CATHETERIZATION	0.000000	0	0
60.00	LABORATORY	0.399246	92,547	36,949
60.01	BLOOD LABORATORY	0.000000	0	0
63.00	BLOOD STORING, PROCESSING, & TRANS.	0.000000	0	0
64.00	INTRAVENOUS THERAPY	0.000000	0	0
65.00	RESPIRATORY THERAPY	0.373256	80,824	30,168
66.00	PHYSICAL THERAPY	0.393425	358,125	140,895
67.00	OCCUPATIONAL THERAPY	0.000000	0	0
68.00	SPEECH PATHOLOGY	0.000000	0	0
69.00	ELECTROCARDIOLOGY	0.058477	2,921	171
70.00	ELECTROENCEPHALOGRAPHY	0.000000	0	0
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.181789	81,859	14,881
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.351832	0	0
73.00	DRUGS CHARGED TO PATIENTS	0.294797	332,026	97,880
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	CLINIC	0.000000	0	0
91.00	EMERGENCY	0.507195	0	0
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.888209	0	0
200.00	Total (sum of lines 50-94 and 96-98)		993,489	333,776
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0
202.00	Net charges (line 200 minus line 201)		993,489	333,776

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151325	Period: From 07/01/2010 To 06/30/2011	Worksheet D-3	
		Title XIX	Hospital	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	ADULTS & PEDIATRICS		64,452		30.00
31.00	INTENSIVE CARE UNIT		0		31.00
40.00	SUBPROVIDER - IPF		0		40.00
41.00	SUBPROVIDER - IRF		0		41.00
42.00	SUBPROVIDER		0		42.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	OPERATING ROOM	0.479907	276,706	132,793	50.00
51.00	RECOVERY ROOM	0.000000	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	ANESTHESIOLOGY	0.125467	22,560	2,831	53.00
54.00	RADIOLOGY - DIAGNOSTIC	0.257671	1,398,086	360,246	54.00
56.00	RADIOISOTOPE	0.000000	0	0	56.00
57.00	CT SCAN	0.000000	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	LABORATORY	0.399246	548,709	219,070	60.00
60.01	BLOOD LABORATORY	0.000000	0	0	60.01
63.00	BLOOD STORING, PROCESSING, & TRANS.	0.000000	0	0	63.00
64.00	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	RESPIRATORY THERAPY	0.373256	123,496	46,096	65.00
66.00	PHYSICAL THERAPY	0.393425	57,603	22,662	66.00
67.00	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	ELECTROCARDIOLOGY	0.058477	32,538	1,903	69.00
70.00	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.181789	188,048	34,185	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.351832	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.294797	288,124	84,938	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	CLINIC	0.000000	0	0	90.00
91.00	EMERGENCY	0.507195	2,458,695	1,247,038	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.888209	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		5,394,565	2,151,762	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		5,394,565		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151325	Period: From 07/01/2010 To 06/30/2011	Worksheet E Part B Date/Time Prepared: 1/26/2012 12:42 pm
		Title XVIII	Hospital	Cost

		1.00	
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>			
1.00	Medical and other services (see instructions)	2,004,070	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	2,004,070	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>			
<b>Reasonable charges</b>			
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
<b>Customary charges</b>			
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	2,024,111	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	0	24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>			
25.00	Deductibles and coinsurance (for CAH, see instructions)	13,084	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	939,101	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)	1,071,926	27.00
28.00	Direct graduate medical education payments (from worksheet E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from worksheet E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	1,071,926	30.00
31.00	Primary payer payments	842	31.00
32.00	Subtotal (line 30 minus line 31)	1,071,084	32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>			
33.00	Composite rate ESRD (from worksheet I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	232,591	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	232,591	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	232,591	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)	1,303,675	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)	1,303,675	40.00
41.00	Interim payments	1,088,464	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)	215,211	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>			
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151325	Period: From 07/01/2010 To 06/30/2011	Worksheet E Part B Date/Time Prepared: 1/26/2012 12:42 pm
		Title XVIII	Hospital	Cost
				Overrides
				1.00
<b>WORKSHEET OVERRIDE VALUES</b>				
112.00	override of Ancillary service charges (line 12)			0   112.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151325 Component CCN: 15M325	Period: From 07/01/2010 To 06/30/2011	Worksheet E Part B Date/Time Prepared: 1/26/2012 12:43 pm
		Title XVIII	Subprovider - IPF	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151325 Component CCN: 15M325	Period: From 07/01/2010 To 06/30/2011	Worksheet E Part B Date/Time Prepared: 1/26/2012 12:43 pm
	Title XVIII	Subprovider - IPF	PPS
	Overrides		
	1.00		
112.00	WORKSHEET OVERRIDE VALUES Override of Ancillary service charges (line 12)		0

112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 151325		Period: From 07/01/2010 To 06/30/2011		Worksheet E-1 Part I Date/Time Prepared: 1/26/2012 12:42 pm	
		Title XVIII		Hospital		Cost	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		1,126,002		1,428,216	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
<b>Program to Provider</b>							
3.01	ADJUSTMENTS TO PROVIDER	01/13/2011	46,452	01/13/2011	48,556	3.01	
3.02		06/28/2011	197,394		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
<b>Provider to Program</b>							
3.50	ADJUSTMENTS TO PROGRAM	06/07/2011	245,469	06/28/2011	6,381	3.50	
3.51			0	06/07/2011	381,927	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)		-1,623		-339,752	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)		1,124,379		1,088,464	4.00	
<b>TO BE COMPLETED BY CONTRACTOR</b>							
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
<b>Program to Provider</b>							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
<b>Provider to Program</b>							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)						6.00
6.01	SETTLEMENT TO PROVIDER		0		215,211	6.01	
6.02	SETTLEMENT TO PROGRAM		55,216		0	6.02	
7.00	Total Medicare program liability (see instructions)		1,069,163		1,303,675	7.00	
				Contractor Number	Date (Mo/Day/Yr)		
			0	1.00	2.00		
8.00	Name of Contractor						8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CCN: 151325 Component CCN: 15M325	Period: From 07/01/2010 To 06/30/2011	Worksheet E-1 Part I Date/Time Prepared: 1/26/2012 12:42 pm
	Title XVIII	Subprovider - IPF	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		1,992,971		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
<b>Program to Provider</b>						
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
<b>Provider to Program</b>						
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)		1,992,971		0	4.00
<b>TO BE COMPLETED BY CONTRACTOR</b>						
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
<b>Program to Provider</b>						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
<b>Provider to Program</b>						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,992,971		0	7.00
				Contractor Number	Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 151325	Period: From 07/01/2010 To 06/30/2011	Worksheet E-1 Part I Date/Time Prepared: 1/26/2012 12:42 pm	
		Title XVIII	Swing Beds - SNF	Cost	
		Inpatient Part A		Part B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount
		1.00	2.00	3.00	4.00
1.00	Total interim payments paid to provider		1,208,388		0
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				3.00
<b>Program to Provider</b>					
3.01	ADJUSTMENTS TO PROVIDER	06/28/2011	110,480		0
3.02			0		0
3.03			0		0
3.04			0		0
3.05			0		0
<b>Provider to Program</b>					
3.50	ADJUSTMENTS TO PROGRAM	06/07/2011	259,275		0
3.51			0		0
3.52			0		0
3.53			0		0
3.54			0		0
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		-148,795		0
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,059,593		0
<b>TO BE COMPLETED BY CONTRACTOR</b>					
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
<b>Program to Provider</b>					
5.01	TENTATIVE TO PROVIDER		0		0
5.02			0		0
5.03			0		0
<b>Provider to Program</b>					
5.50	TENTATIVE TO PROGRAM		0		0
5.51			0		0
5.52			0		0
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				6.00
6.01	SETTLEMENT TO PROVIDER		51,855		0
6.02	SETTLEMENT TO PROGRAM		0		0
7.00	Total Medicare program liability (see instructions)		1,111,448		0
				Contractor Number	Date (Mo/Day/Yr)
			0	1.00	2.00
8.00	Name of Contractor				8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 151325

Period:

Worksheet E-2

Component CCN: 152325

From 07/01/2010

Date/Time Prepared:

To 06/30/2011

1/26/2012 12:42 pm

		Title XVIII		Swing Beds - SNF		Cost	
		Part A	Part B	Part A	Part B		
		1.00	2.00	1.00	2.00		
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>							
1.00	Inpatient routine services - swing bed-SNF (see instructions)			816,910	0	1.00	
2.00	Inpatient routine services - swing bed-NF (see instructions)					2.00	
3.00	Ancillary services (from wkst. D-3, column 3, line 200 for Part A, and sum of wkst. D, Part V, columns 5 and 7, line 202 for Part B) (For CAH, see instructions)			337,114	0	3.00	
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)				0.00	4.00	
5.00	Program days			1,371	0	5.00	
6.00	Interns and residents not in approved teaching program (see instructions)				0	6.00	
7.00	Utilization review - physician compensation - SNF optional method only			0		7.00	
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)			1,154,024	0	8.00	
9.00	Primary payer payments (see instructions)			2,003	0	9.00	
10.00	Subtotal (line 8 minus line 9)			1,152,021	0	10.00	
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)			0	0	11.00	
12.00	Subtotal (line 10 minus line 11)			1,152,021	0	12.00	
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)			40,573	0	13.00	
14.00	80% of Part B costs (line 12 x 80%)				0	14.00	
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)			1,111,448	0	15.00	
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	0	16.00	
17.00	Reimbursable bad debts (see instructions)			0	0	17.00	
18.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			0	0	18.00	
19.00	Total (sum of lines 15 and 17, plus/minus line 16)			1,111,448	0	19.00	
20.00	Interim payments			1,059,593	0	20.00	
21.00	Tentative settlement (for contractor use only)			0	0	21.00	
22.00	Balance due provider/program (line 19 minus the sum of lines 20 and 21)			51,855	0	22.00	
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			0	0	23.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151325	Period: From 07/01/2010 To 06/30/2011	Worksheet E-3 Part V Date/Time Prepared: 1/26/2012 12:42 pm
	Title XVIII	Hospital	Cost

			1.00	
<b>PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)</b>				
1.00	Inpatient services		1,251,734	1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction)		0	2.00
3.00	Organ acquisition		0	3.00
4.00	Subtotal (sum of lines 1 thru 3)		1,251,734	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 5 less line 6) . For CAH (see instructions)		1,264,251	6.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
7.00	Routine service charges		0	7.00
8.00	Ancillary service charges		0	8.00
9.00	Organ acquisition charges, net of revenue		0	9.00
10.00	Total reasonable charges		0	10.00
<b>Customary charges</b>				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)		0.000000	13.00
14.00	Total customary charges (see instructions)		0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)		0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)		0	16.00
17.00	Cost of teaching physicians (from worksheet D-5, Part II, column 3, line 20) (see instructions)		0	17.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
18.00	Direct graduate medical education payments (from worksheet E-4, line 49)		0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)		1,264,251	19.00
20.00	Deductibles (exclude professional component)		229,141	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus sum of lines 20 and 21)		1,035,110	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		1,035,110	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		34,053	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		34,053	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		34,053	27.00
28.00	Subtotal (sum of lines 24 and 25 or 26(line 26 hospital and subprovider only))		1,069,163	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	29.00
29.99	Recovery of Accelerated Depreciation		0	29.99
30.00	Subtotal (line 28, plus or minus lines 29)		1,069,163	30.00
31.00	Interim payments		1,124,379	31.00
32.00	Tentative settlement (for contractor use only)		0	32.00
33.00	Balance due provider/program (line 30 minus the sum of lines 31, and 32)		-55,216	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151325	Period: From 07/01/2010	Worksheet E-3
	Component CCN: 15M325	To 06/30/2011	Part II Date/Time Prepared: 1/26/2012 12:42 pm
	Title XVIII	Subprovider - IPF	PPS

		1.00	
<b>PART II - MEDICARE PART A SERVICES - IPF PPS</b>			
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	2,130,219	1.00
2.00	Net IPF PPS Outlier Payments	3,777	2.00
3.00	Net IPF PPS ECT Payments	0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)	0.00	4.00
5.00	New Teaching program adjustment. (see instructions)	0.00	5.00
6.00	Current year's unweighted FTE count of I&R other than FTEs in the first 3 years of a "new teaching program". (see inst.)	0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the first 3 years of a "new teaching program". (see inst.)	0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00	8.00
9.00	Average Daily Census (see instructions)	9.282192	9.00
10.00	Medical Education Adjustment Factor $\{(1 + (\text{line 8}/\text{line 9})) \text{ raised to the power of } .5150 - 1\}$ .	0.000000	10.00
11.00	Medical Education Adjustment (line 1 multiplied by line 10).	0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	2,133,996	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)	0	13.00
14.00	Organ acquisition	0	14.00
15.00	Cost of teaching physicians (from worksheet D-5, Part II, column 3, line 20) (see instructions)	0	15.00
16.00	Subtotal (see instructions)	2,133,996	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	2,133,996	18.00
19.00	Deductibles	114,676	19.00
20.00	Subtotal (line 18 minus line 19)	2,019,320	20.00
21.00	Coinsurance	26,349	21.00
22.00	Subtotal (line 20 minus line 21)	1,992,971	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	0	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	25.00
26.00	Subtotal (sum of lines 22 and 24)	1,992,971	26.00
27.00	Direct graduate medical education payments (from worksheet E-4, line 49)	0	27.00
28.00	Other pass through costs (see instructions)	0	28.00
29.00	Outlier payments reconciliation	0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.00
30.99	Recovery of Accelerated Depreciation	0	30.99
31.00	Total amount payable to the provider (see instructions)	1,992,971	31.00
32.00	Interim payments	1,992,971	32.00
33.00	Tentative settlement (for contractor use only)	0	33.00
34.00	Balance due provider/program (line 31 minus the sum lines 32 and 33)	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	35.00
<b>TO BE COMPLETED BY CONTRACTOR</b>			
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	0	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151325	Period: From 07/01/2010 To 06/30/2011	Worksheet E-3 Part VII Date/Time Prepared: 1/26/2012 12:43 pm
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	Title XIX	Hospital	Cost
			1.00

PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	2,291,580	1.00
2.00	Medical and other services	0	2.00
3.00	Organ acquisition (certified transplant centers only)	0	3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	2,291,580	4.00
5.00	Inpatient primary payer payments	0	5.00
6.00	Outpatient primary payer payments	0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	2,291,580	7.00
COMPUTATION OF LESSER OF COST OR CHARGES			
Reasonable Charges			
8.00	Routine service charges	64,452	8.00
9.00	Ancillary service charges	5,394,565	9.00
10.00	Organ acquisition charges, net of revenue	0	10.00
11.00	Incentive from target amount computation	0	11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	5,459,017	12.00
CUSTOMARY CHRGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	15.00
16.00	Total customary charges (see instructions)	5,459,017	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 7) (see instructions)	3,167,437	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 7 exceeds line 16) (see instructions)	0	18.00
19.00	Interns and Residents (see instructions)	0	19.00
20.00	Cost of Teaching Physicians (see instructions)	0	20.00
21.00	Cost of covered services (line 7)	2,291,580	21.00
PROSPECTIVE PAYMENT AMOUNT			
22.00	Other than outlier payments	0	22.00
23.00	Outlier payments	0	23.00
24.00	Program capital payments	0	24.00
25.00	Capital exception payments (see instructions)	0	25.00
26.00	Routine and Ancillary service other pass through costs	0	26.00
27.00	Subtotal (sum of lines 22 through 26, plus line 3 minus lines 5 and 6)	0	27.00
28.00	Customary charges (title XIX PPS covered services only)	0	28.00
29.00	Titles V or XIX (see instructions)	2,291,580	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus line 29 minus line 30)	2,291,580	31.00
32.00	Deductibles	0	32.00
33.00	Coinsurance	0	33.00
34.00	Allowable bad debts (see instructions)	0	34.00
35.00	Utilization review	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	2,291,580	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	37.00
38.00	Subtotal (line 36 ± line 37)	2,291,580	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	2,291,580	40.00
41.00	Interim payments	2,291,580	41.00
42.00	Balance due provider/program (line 40 minus 41)	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) Provider CCN: 151325 Period: From 07/01/2010 To 06/30/2011 Worksheet G Date/Time Prepared: 1/26/2012 12:42 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>CURRENT ASSETS</b>						
1.00	Cash on hand in banks	1,017,419	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	4,331,996	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-1,976,168	0	0	0	6.00
7.00	Inventory	187,784	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	185,981	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	<b>Total current assets (sum of lines 1-10)</b>	<b>3,747,012</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>11.00</b>
<b>FIXED ASSETS</b>						
12.00	Land	468,488	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	10,890,573	0	0	0	15.00
16.00	Accumulated depreciation	-7,231,468	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	8,024,861	0	0	0	19.00
20.00	Accumulated depreciation	-6,754,428	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	<b>Total fixed assets (sum of lines 12-29)</b>	<b>5,398,026</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>30.00</b>
<b>OTHER ASSETS</b>						
31.00	Investments	192,303	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	69,480	446,243	0	0	34.00
35.00	<b>Total other assets (sum of lines 31-34)</b>	<b>261,783</b>	<b>446,243</b>	<b>0</b>	<b>0</b>	<b>35.00</b>
36.00	<b>Total assets (sum of lines 11, 30, and 35)</b>	<b>9,406,821</b>	<b>446,243</b>	<b>0</b>	<b>0</b>	<b>36.00</b>
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	496,011	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)	66,849	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	2,462,226	0	0	0	44.00
45.00	<b>Total current liabilities (sum of lines 37 thru 44)</b>	<b>3,025,086</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>45.00</b>
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	4,532,864	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	797,413	0	0	0	49.00
50.00	<b>Total long term liabilities (sum of lines 46 thru 49)</b>	<b>5,330,277</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>50.00</b>
51.00	<b>Total liabilities (sum of lines 45 and 50)</b>	<b>8,355,363</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>51.00</b>
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	1,051,458	0	0	0	52.00
53.00	Specific purpose fund	0	446,243	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	<b>Total fund balances (sum of lines 52 thru 58)</b>	<b>1,051,458</b>	<b>446,243</b>	<b>0</b>	<b>0</b>	<b>59.00</b>
60.00	<b>Total liabilities and fund balances (sum of lines 51 and 59)</b>	<b>9,406,821</b>	<b>446,243</b>	<b>0</b>	<b>0</b>	<b>60.00</b>

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151325

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

Worksheet G-1

Date/Time Prepared:  
1/26/2012 12:42 pm

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

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151325

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

Worksheet G-1

Date/Time Prepared:  
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	Endowment Fund		Plant Fund		
	5.00	6.00	7.00	8.00	
1.00 Fund balances at beginning of period		0		0	1.00
2.00 Net income (loss) (from wkst. G-3, line 29)					2.00
3.00 Total (sum of line 1 and line 2)		0		0	3.00
4.00 DEFERRED PENSION COSTS	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)		0		0	11.00
12.00 TEMP. RESTRICTED CONTRIBUTIONS	0		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)		0		0	18.00
19.00 Fund balance at end of period per balance sheet (line 11 minus line 18)		0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 151325

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

Worksheet G-2 Parts

Date/Time Prepared:  
1/26/2012 12:42 pm

Cost Center Description	Inpatient	Outpatient	Total	
	1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>				
<b>General Inpatient Routine Services</b>				
1.00 Hospital	2,694,891		2,694,891	1.00
2.00 SUBPROVIDER - IPF	4,072,800		4,072,800	2.00
3.00 SUBPROVIDER - IRF	0		0	3.00
4.00 SUBPROVIDER	0		0	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)	6,767,691		6,767,691	10.00
<b>Intensive Care Type Inpatient Hospital Services</b>				
11.00 INTENSIVE CARE UNIT	0		0	11.00
12.00 CORONARY CARE UNIT				12.00
13.00 BURN INTENSIVE CARE UNIT				13.00
14.00 SURGICAL INTENSIVE CARE UNIT				14.00
15.00 OTHER SPECIAL CARE (SPECIFY)				15.00
16.00 Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00 Total inpatient routine care services (sum of lines 10 and 16)	6,767,691		6,767,691	17.00
18.00 Ancillary services	5,898,686	26,779,595	32,678,281	18.00
19.00 Outpatient services	0	0	0	19.00
20.00 RURAL HEALTH CLINIC	0	0	0	20.00
21.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00 HOME HEALTH AGENCY				22.00
23.00 AMBULANCE SERVICES				23.00
24.00 CMHC				24.00
25.00 AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00 HOSPICE				26.00
27.00 NRCC	0	160,002	160,002	27.00
28.00 Total patient revenues (sum of lines 17-27)(transfer column 3 to wkst. G-3, line 1)	12,666,377	26,939,597	39,605,974	28.00
<b>PART II - OPERATING EXPENSES</b>				
29.00 Operating expenses (per wkst. A, column 3, line 200)		14,711,676		29.00
30.00 BAD DEBT EXPENSE	4,093,865			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)		4,093,865		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)		18,805,541		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 151325	Period: From 07/01/2010 To 06/30/2011	Worksheet G-3 Date/Time Prepared: 1/26/2012 12:42 pm
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		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	39,605,974	1.00
2.00	Less contractual allowances and discounts on patients' accounts	20,594,156	2.00
3.00	Net patient revenues (line 1 minus line 2)	19,011,818	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	18,805,541	4.00
5.00	Net income from service to patients (line 3 minus line 4)	206,277	5.00
<b>OTHER INCOME</b>			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	29,394	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	165	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	27,890	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	198	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	4,354	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING REVENUE	1,326	24.00
24.01	EXERCISE REVENUE	30,136	24.01
24.02	HOUSEKEEPING REVENUE	8,040	24.02
24.03	OTHER MAINTENANCE REVENUE	450	24.03
24.04	GRANT REVENUE	5,176	24.04
24.05	EDUCATION REVENUE	30	24.05
24.06	OTHER LAB REVENUE	30	24.06
24.07	INCOME - GENESIS	1,430	24.07
24.08		0	24.08
25.00	Total other income (sum of lines 6-24)	108,619	25.00
26.00	Total (line 5 plus line 25)	314,896	26.00
27.00	ROUNDING	4	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	4	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	314,892	29.00