

**ST. VINCENT CLAY HOSPITAL
BRAZIL, INDIANA**

**PROVIDER NO. 15-1309 and 15-Z309
AND AIM NO. 200448850**

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

JUNE 30, 2011

ST. VINCENT CLAY HOSPITAL
PROVIDER NOS. 15-1309 and 15-Z309
AND AIM NO. 200448850

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Accountants' Disclaimer

Hospital Statements of Reimbursable Costs



Board of Directors
St. Vincent Clay Hospital
Brazil, Indiana

We have compiled the Hospital Statement of Reimbursable Costs (Title XVIII and XIX) of St. Vincent Clay 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 30, 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: 151309	Period: From 07/01/2010 To 06/30/2011	Worksheet 5 Parts I-III Date/Time Prepared: 1/31/2012 9:03 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: 1/31/2012	Time: 9:03 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. VINCENT CLAY HOSPITAL for the cost reporting period beginning 07/01/2010 and ending 06/30/2011 and to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services identified in this cost report were provided in compliance with such laws and regulations.

Encryption Information

ECR: Date: 1/31/2012 Time: 9:03 am
fxxwsd0lkwdfo5qiIcsm0ZHEoGQc80
LOico0Rq.18xgpavc.31iyX0scd5hr
6JpW06:4Sm069Dg3
PI: Date: 1/31/2012 Time: 9:03 am
614q:pachLqIvwuSjOdH02xxD0eyj0
C4EM20qLJJPdfoheyiv:32GZknd5up
qZjnh2kxub06wvkq

(Signed) *Wm Z LWA*
Officer or Administrator of Provider(s)
Wm Z LWA
Title
1/31/2012
Date

	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	258,259	-153,660	0	-5,616	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	117,149	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	375,408	-153,660	0	-5,616	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: 151309

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

Worksheet S-2
Part I
Date/Time Prepared:
1/31/2012 8:54 am

		1.00	2.00	3.00	4.00					
Hospital and Hospital Health Care Complex Address:										
1.00	Street:1206 EAST NATIONAL AVENUE	PO Box:		Zip Code: 47834		County: CLAY		1.00		
2.00	City: BRAZIL	State: IN		Zip Code: 47834		County: CLAY		2.00		
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
							V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
Hospital and Hospital-Based Component Identification:										
3.00	Hospital	ST. VINCENT CLAY HOSPITAL	151309	45460	1	08/08/2001	N	O	O	
4.00	Subprovider - IPF								4.00	
5.00	Subprovider - IRF								5.00	
6.00	Subprovider - (Other)								6.00	
7.00	Swing Beds - SNF	ST. VINCENT CLAY SWING BEDS	152309	45460		08/08/2001	N	O	N	
8.00	Swing Beds - NF						N		N	
9.00	Hospital-Based SNF								9.00	
10.00	Hospital-Based NF								10.00	
11.00	Hospital-Based OLTC								11.00	
12.00	Hospital-Based HHA								12.00	
13.00	Separately Certified ASC								13.00	
14.00	Hospital-Based Hospice								14.00	
15.00	Hospital-Based Health Clinic - RHC								15.00	
16.00	Hospital-Based Health Clinic - FQHC								16.00	
17.00	Hospital-Based (CMHC) 1								17.00	
18.00	Renal Dialysis								18.00	
19.00	Other								19.00	
							From:	To:		
							1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)						07/01/2010	06/30/2011		20.00
21.00	Type of Control (see instructions)						1			21.00
Inpatient PPS Information:										
22.00	Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N		N		22.00
23.00	Indicate in column 1 the method used to capture Medicaid (title XIX) days reported on lines 24 and/or 25 of this worksheet during the cost reporting period by entering a "1" if days are based on the date of admission, "2" if days are based on census days (also referred to as the day count), or "3" if the days are based on the date of discharge. Is the method of identifying the days in the current cost reporting period different from the method used in the prior cost reporting period? Enter in column 2 "Y" for yes or "N" for no.					2		N		23.00
		In-State Medicaid paid days	In-State Medicaid eligible days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible days	Medicaid HMO days	Other Medicaid days			
		1.00	2.00	3.00	4.00	5.00	6.00			
24.00	If line 22 and/or line 45 is "yes", and this provider is an IPPS hospital enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible days in col. 4, Medicaid HMO days in col. 5, and other Medicaid days in col. 6.	0	0	0	0	0	0			
25.00	If this provider is an IRF, enter the in-State Medicaid paid days in column 1, the in State Medicaid eligible days in column 2, the out of State Medicaid paid days in column 3, the out of State Medicaid eligible days in column 4, Medicaid HMO days in column 5, and other Medicaid days in column 6. For all columns include in these days the labor and delivery days.	0	0	0	0	0	0			
							1.00			
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter (1) for urban or (2) for rural.									2 26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period? Enter (1) for urban or (2) for rural.									2 27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.									0 35.00
							Beginning:	Ending:		
							1.00	2.00		
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.									36.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151309	Period: From 07/01/2010 To 06/30/2011	Worksheet S-2 Part I Date/Time Prepared: 1/31/2012 8:54 am	
			Beginning:	Ending:	
			1.00	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
Prospective Payment System (PPS)-Capital					
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)		N	N	N
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
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
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.		N	N	N
Teaching Hospitals					
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.		N		
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.				
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.				
59.00	Are costs claimed on line 100 of worksheet A? If yes, complete worksheet D-2, Part I.		N		
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		
			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
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)					
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)		0.00		
62.01	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		
Teaching Hospitals that Claim Residents in Non-Provider Settings					
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete lines 64-67. (see instructions)		N		
			Unweighted FTEs Nonprovider Site 1.00	Unweighted FTEs in Hospital 2.00	Ratio (col. 1/ (col. 1 + col. 2)) 3.00
Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.					
64.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000
			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: 151309

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

Worksheet S-2
Part I
Date/Time Prepared:
1/31/2012 8:54 am

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
		1.00	2.00	3.00	4.00	5.00		
65.00	Enter in column 1 the program name. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00	
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
				1.00	2.00	3.00		
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	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				N		70.00	
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)					0	71.00	
75.00	Inpatient Rehabilitation Facility PPS Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				N		75.00	
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)					0	76.00	
						1.00		
80.00	Long Term Care Hospital PPS 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: 151309	Period: From 07/01/2010 To 06/30/2011	Worksheet S-2 Part I Date/Time Prepared: 1/31/2012 8:54 am	
			1.00		
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			N	86.00
			V 1.00	XIX 2.00	
Title V or XIX Inpatient Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N	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.			Y	92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	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	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	97.00
Rural Providers					
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?			Y	105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			N	106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)			N	107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			N	108.00
		Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	Y		N	109.00
			1.00	2.00	
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2.			N	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.			N	116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.			Y	117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.			1	118.00
119.00	What is the liability limit for the malpractice insurance policy? Enter in column 1 the monetary limit per lawsuit. Enter in column 2 the monetary limit per policy year.			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	120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.			Y	121.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.			N	125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00

1/31/2012 8:54 am X:\HFSdata\clients\Hospital\St Vincent\Clay\2609-11.mcrx

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 151309	Period: From 07/01/2010 To 06/30/2011	Worksheet S-2 Part I Date/Time Prepared: 1/31/2012 8:54 am
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		1.00	2.00					
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00				
All Providers								
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	15H046	140.00				
		1.00	2.00	3.00				
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.								
141.00	Name: ST. VINCENT HEALTH	Contractor's Name: NATIONAL GOVERNMENT SERVICES	Contractor's Number: 00130	141.00				
142.00	Street: 10330 N. MERIDIAN ST.	PO Box:		142.00				
143.00	City: INDIANAPOLIS	State: IN	Zip Code: 46290	143.00				
		1.00						
144.00	Are provider based physicians' costs included in worksheet A?	Y		144.00				
145.00	If costs for renal services are claimed on worksheet A, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.	N		145.00				
		1.00	2.00					
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00				
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N		147.00				
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N		148.00				
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N		149.00				
		Part A	Part B					
		1.00	2.00					
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)								
155.00	Hospital	N	N	155.00				
156.00	Subprovider - IPF	N	N	156.00				
157.00	Subprovider - IRF	N	N	157.00				
158.00	Subprovider - Other	N	N	158.00				
159.00	SNF	N	N	159.00				
160.00	HHA	N	N	160.00				
161.00	CMHC	N	N	161.00				
		1.00						
Multicampus								
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.		N	165.00				
		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00	166.00
							1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act								
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.						N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)							0168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 151309	Period: From 07/01/2010 To 06/30/2011	Worksheet S-2 Part II Date/Time Prepared: 1/31/2012 8:54 am
		Y/N 1.00	Date 2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "v" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions)	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 1.00	Legal Oper. 2.00	
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N		9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
		Y/N 1.00		
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N		14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N		15.00
		Y/N 1.00		
		Description 0	Part A Y/N 1.00	Date 2.00
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	11/08/2011	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for other? Describe the other adjustments:	N		20.00

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

		Part B		
		Y/N	Date	
		3.00	4.00	
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	11/08/2011	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		21.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151309

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

Worksheet S-3
Part I
Date/Time Prepared:
1/31/2012 8:54 am

Cost Center Description	Worksheet A	No. of Beds	Bed Days Available	CAH Hours		
	Line Number					
	1.00	2.00	3.00	4.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	25	9,125	48,480.00		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	48,480.00		7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		25	9,125	48,480.00		14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		25				27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151309

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

Worksheet S-3
Part I
Date/Time Prepared:
1/31/2012 8:54 am

Cost Center Description	I/P Days / O/P Visits / Trips				Total All Patients	
	Title V	Title XVIII	Title XIX			
	5.00	6.00	7.00	8.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, observation Bed and Hospice days)	0	1,418	222	2,020	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	801	0	801	5.00	
6.00 Hospital Adults & Peds. Swing Bed NF	0		0	127	6.00	
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	0	2,219	222	2,948	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	2,219	222	2,948	14.00	
15.00 CAH visits	0	0	0	0	15.00	
16.00 SUBPROVIDER - IPF					16.00	
17.00 SUBPROVIDER - IRF					17.00	
18.00 SUBPROVIDER					18.00	
19.00 SKILLED NURSING FACILITY					19.00	
20.00 NURSING FACILITY					20.00	
21.00 OTHER LONG TERM CARE					21.00	
22.00 HOME HEALTH AGENCY					22.00	
23.00 AMBULATORY SURGICAL CENTER (D.P.)					23.00	
24.00 HOSPICE					24.00	
25.00 CMHC - CMHC					25.00	
26.00 RURAL HEALTH CLINIC					26.00	
26.25 FEDERALLY QUALIFIED HEALTH CENTER					26.25	
27.00 Total (sum of lines 14-26)					27.00	
28.00 Observation Bed Days	0		0	536	28.00	
29.00 Ambulance Trips		0			29.00	
30.00 Employee discount days (see instruction)				16	30.00	
31.00 Employee discount days - IRF				0	31.00	
32.00 Labor & delivery days (see instructions)			0	0	32.00	
33.00 LTCH non-covered days		0			33.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151309

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

Worksheet S-3
Part I
Date/Time Prepared:
1/31/2012 8:54 am

Cost Center Description	Full Time Equivalents			Discharges	Title XVIII	
	Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V		
	9.00	10.00	11.00	12.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)				0	404	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	150.32	0.00	0	404	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)	0.00	150.32	0.00			27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

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)	66	615		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)	66	615		14.00
15.00 CAH visits				15.00
16.00 SUBPROVIDER - IPF				16.00
17.00 SUBPROVIDER - IRF				17.00
18.00 SUBPROVIDER				18.00
19.00 SKILLED NURSING FACILITY				19.00
20.00 NURSING FACILITY				20.00
21.00 OTHER LONG TERM CARE				21.00
22.00 HOME HEALTH AGENCY				22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)				23.00
24.00 HOSPICE				24.00
25.00 CMHC - CMHC				25.00
26.00 RURAL HEALTH CLINIC				26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER				26.25
27.00 Total (sum of lines 14-26)				27.00
28.00 Observation Bed Days				28.00
29.00 Ambulance Trips				29.00
30.00 Employee discount days (see instruction)				30.00
31.00 Employee discount days - IRF				31.00
32.00 Labor & delivery days (see instructions)				32.00
33.00 LTCH non-covered days				33.00

				1.00		
Uncompensated and indigent care cost computation						
1.00	Cost to charge ratio (Worksheet C, Part I line 200 column 3 divided by line 200 column 8)			0.332237	1.00	
Medicaid (see instructions for each line)						
2.00	Net revenue from Medicaid			1,124,709	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?			N	3.00	
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?				4.00	
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid			0	5.00	
6.00	Medicaid charges			8,691,724	6.00	
7.00	Medicaid cost (line 1 times line 6)			2,887,712	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)			1,763,003	8.00	
State Children's Health Insurance Program (SCHIP) (see instructions for each line)						
9.00	Net revenue from stand-alone SCHIP			0	9.00	
10.00	Stand-alone SCHIP charges			0	10.00	
11.00	Stand-alone SCHIP cost (line 1 times line 10)			0	11.00	
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)			0	12.00	
Other state or local government indigent care program (see instructions for each line)						
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)			0	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)			0	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)			0	15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)			0	16.00	
Uncompensated care (see instructions for each line)						
17.00	Private grants, donations, or endowment income restricted to funding charity care			0	17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations			15,032	18.00	
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)			1,763,003	19.00	
				Uninsured patients 1.00	Insured patients 2.00	Total (col. 1 + col. 2) 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	2,968,234	1,481	2,969,715	20.00	
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	986,157	492	986,649	21.00	
22.00	Partial payment by patients approved for charity care	0	0	0	22.00	
23.00	Cost of charity care (line 21 minus line 22)	986,157	492	986,649	23.00	
				1.00		
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			N	24.00	
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit			0	25.00	
26.00	Total bad debt expense for the entire hospital complex (see instructions)			4,279,640	26.00	
27.00	Medicare bad debts for the entire hospital complex (see instructions)			501,524	27.00	
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)			3,778,116	28.00	
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)			1,255,230	29.00	
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)			2,241,879	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			4,004,882	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES			Provider CCN: 151309	Period: From 07/01/2010 To 06/30/2011	Worksheet A	Date/Time Prepared: 1/31/2012 8:54 am	
Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)		
	1.00	2.00	3.00	4.00	5.00		
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT		509,845	509,845	-243,159	266,686	1.00
2.00	CAP REL COSTS-MVBLE EQUIP		1,135,511	1,135,511	159,093	1,294,604	2.00
2.01	CAP REL COSTS-MOB		368,310	368,310	0	368,310	2.01
4.00	EMPLOYEE BENEFITS	97,894	2,247,076	2,344,970	0	2,344,970	4.00
5.00	ADMINISTRATIVE & GENERAL	1,633,806	1,654,832	3,288,638	84,066	3,372,704	5.00
7.00	OPERATION OF PLANT	315,608	464,025	779,633	0	779,633	7.00
8.00	LAUNDRY & LINEN SERVICE	0	57,302	57,302	0	57,302	8.00
9.00	HOUSEKEEPING	215,071	55,289	270,360	0	270,360	9.00
10.00	DIETARY	217,205	80,670	297,875	-149,384	148,491	10.00
11.00	CAFETERIA	0	0	0	149,384	149,384	11.00
13.00	NURSING ADMINISTRATION	298,846	45,999	344,845	22,176	367,021	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	11,942	11,942	0	11,942	14.00
15.00	PHARMACY	0	1,188,306	1,188,306	-779,827	408,479	15.00
16.00	MEDICAL RECORDS & LIBRARY	242,588	21,241	263,829	0	263,829	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	980,175	85,929	1,066,104	0	1,066,104	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	480,052	194,767	674,819	-51,209	623,610	50.00
53.00	ANESTHESIOLOGY	323,906	3,233	327,139	0	327,139	53.00
54.00	RADIOLOGY - DIAGNOSTIC	632,572	312,090	944,662	-47,978	896,684	54.00
60.00	LABORATORY	357,930	720,477	1,078,407	0	1,078,407	60.00
65.00	RESPIRATORY THERAPY	188,423	49,836	238,259	-32,469	205,790	65.00
66.00	PHYSICAL THERAPY	0	571,088	571,088	0	571,088	66.00
68.00	SPEECH PATHOLOGY	643	3,316	3,959	0	3,959	68.00
69.00	ELECTROCARDIOLOGY	89,202	14,441	103,643	0	103,643	69.00
70.00	ELECTROENCEPHALOGRAPHY	2,594	0	2,594	0	2,594	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	572,699	572,699	201,109	773,808	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	311,350	311,350	-110,997	200,353	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	6,579	6,579	827,805	834,384	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	EMERGENCY	794,086	594,789	1,388,875	-6,434	1,382,441	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	6,870,601	11,280,942	18,151,543	22,176	18,173,719	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	37,763	37,763	0	37,763	192.00
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	CLAY CITY MEDICAL CLINIC	186,457	105,699	292,156	0	292,156	193.01
193.02	PUBLIC RELATIONS	44,351	748	45,099	-22,176	22,923	193.02
193.03	FOUNDATION	0	13,980	13,980	0	13,980	193.03
193.04	MISSION SERVICES	0	2,714	2,714	0	2,714	193.04
193.05	OTHER NON-REIMBURSABLE	0	0	0	0	0	193.05
200.00	TOTAL (SUM OF LINES 118-199)	7,101,409	11,441,846	18,543,255	0	18,543,255	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151309

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

Worksheet A
Date/Time Prepared:
1/31/2012 8:54 am

Cost Center Description		Adjustments (See A-8) 6.00	Net Expenses For Allocation 7.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	123,691	390,377	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	-150,326	1,144,278	2.00
2.01	CAP REL COSTS-MOB	0	368,310	2.01
4.00	EMPLOYEE BENEFITS	204,920	2,549,890	4.00
5.00	ADMINISTRATIVE & GENERAL	376,687	3,749,391	5.00
7.00	OPERATION OF PLANT	-2,563	777,070	7.00
8.00	LAUNDRY & LINEN SERVICE	0	57,302	8.00
9.00	HOUSEKEEPING	0	270,360	9.00
10.00	DIETARY	0	148,491	10.00
11.00	CAFETERIA	-36,089	113,295	11.00
13.00	NURSING ADMINISTRATION	0	367,021	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	11,942	14.00
15.00	PHARMACY	0	408,479	15.00
16.00	MEDICAL RECORDS & LIBRARY	0	263,829	16.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	0	1,066,104	30.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0	623,610	50.00
53.00	ANESTHESIOLOGY	-327,139	0	53.00
54.00	RADIOLOGY - DIAGNOSTIC	0	896,684	54.00
60.00	LABORATORY	0	1,078,407	60.00
65.00	RESPIRATORY THERAPY	0	205,790	65.00
66.00	PHYSICAL THERAPY	0	571,088	66.00
68.00	SPEECH PATHOLOGY	0	3,959	68.00
69.00	ELECTROCARDIOLOGY	0	103,643	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	2,594	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	773,808	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	200,353	72.00
73.00	DRUGS CHARGED TO PATIENTS	-308	834,076	73.00
OUTPATIENT SERVICE COST CENTERS				
91.00	EMERGENCY	-62,500	1,319,941	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
SPECIAL PURPOSE COST CENTERS				
118.00	SUBTOTALS (SUM OF LINES 1-117)	126,373	18,300,092	118.00
NONREIMBURSABLE COST CENTERS				
190.00	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	37,763	192.00
193.00	NONPAID WORKERS	0	0	193.00
193.01	CLAY CITY MEDICAL CLINIC	0	292,156	193.01
193.02	PUBLIC RELATIONS	238,800	261,723	193.02
193.03	FOUNDATION	0	13,980	193.03
193.04	MISSION SERVICES	0	2,714	193.04
193.05	OTHER NON-REIMBURSABLE	0	0	193.05
200.00	TOTAL (SUM OF LINES 118-199)	365,173	18,908,428	200.00

RECLASSIFICATIONS

Provider CCN: 151309

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

Worksheet A-6

Date/Time Prepared:
1/31/2012 8:54 am

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - NURSING EDUCATION					
1.00	NURSING ADMINISTRATION	13.00	22,176	0	1.00
	TOTALS		22,176	0	
B - INTEREST					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	84,066	1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	76,892	2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	150,326	3.00
	TOTALS		0	311,284	
C - CAFETERIA					
1.00	CAFETERIA	11.00	108,928	40,456	1.00
	TOTALS		108,928	40,456	
D - PROPERTY INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	4,484	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	8,767	2.00
	TOTALS		0	13,251	
E - SUPPLIES RECLASS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	760,285	1.00
2.00	DRUGS CHARGED TO PATIENTS	73.00	0	834,076	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
	TOTALS		0	1,594,361	
F - IMPLANTABLE DEVICES					
1.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	72.00	0	186,538	1.00
	TOTALS		0	186,538	
500.00	Grand Total: Increases		131,104	2,145,890	500.00

RECLASSIFICATIONS

Provider CCN: 151309

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

Worksheet A-6

Date/Time Prepared:
1/31/2012 8:54 am

		Decreases				wkst. A-7 Ref.	
	Cost Center	Line #	Salary	Other			
	6.00	7.00	8.00	9.00	10.00		
A - NURSING EDUCATION							
1.00	PUBLIC RELATIONS	193.02	22,176	0	0		1.00
	TOTALS		22,176	0			
B - INTEREST							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	227,218	11		1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	84,066	11		2.00
3.00		0.00	0	0	11		3.00
	TOTALS		0	311,284			
C - CAFETERIA							
1.00	DIETARY	10.00	108,928	40,456	0		1.00
	TOTALS		108,928	40,456			
D - PROPERTY INSURANCE							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	13,251	11		1.00
2.00		0.00	0	0	11		2.00
	TOTALS		0	13,251			
E - SUPPLIES RECLASS							
1.00	PHARMACY	15.00	0	779,827	0		1.00
2.00	OPERATING ROOM	50.00	0	51,209	0		2.00
3.00	RADIOLOGY - DIAGNOSTIC	54.00	0	47,978	0		3.00
4.00	RESPIRATORY THERAPY	65.00	0	32,469	0		4.00
5.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	372,638	0		5.00
6.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	72.00	0	297,535	0		6.00
7.00	DRUGS CHARGED TO PATIENTS	73.00	0	6,271	0		7.00
8.00	EMERGENCY	91.00	0	6,434	0		8.00
	TOTALS		0	1,594,361			
F - IMPLANTABLE DEVICES							
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	186,538	0		1.00
	TOTALS		0	186,538			
500.00	Grand Total: Decreases		131,104	2,145,890			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151309

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
1/31/2012 8:54 am

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
		1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	2,500	0	0	0	1.00
2.00	Land Improvements	317,947	0	0	0	2.00
3.00	Buildings and Fixtures	8,844,102	156,569	0	156,569	3.00
4.00	Building Improvements	0	0	0	0	4.00
5.00	Fixed Equipment	8,813,402	488,143	0	488,143	5.00
6.00	Movable Equipment	0	0	0	0	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	17,977,951	644,712	0	644,712	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	17,977,951	644,712	0	644,712	10.00
SUMMARY OF CAPITAL						
Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
	9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2					
1.00	CAP REL COSTS-BLDG & FIXT	185,309	0	311,285	13,251	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	320,363	814,164	0	984	2.00
2.01	CAP REL COSTS-MOB	41,924	326,386	0	0	2.01
3.00	Total (sum of lines 1-2)	547,596	1,140,550	311,285	14,235	3.00
COMPUTATION OF RATIOS						
Cost Center Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL Ratio (see instructions)	Insurance	
	1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1.000000	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	2.00
2.01	CAP REL COSTS-MOB	0	0	0	0.000000	2.01
3.00	Total (sum of lines 1-2)	0	0	0	1.000000	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151309

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
1/31/2012 8:54 am

		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	2,500	0				1.00
2.00	Land Improvements	317,947	0				2.00
3.00	Buildings and Fixtures	9,000,671	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	9,301,545	0				5.00
6.00	Movable Equipment	0	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	18,622,663	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	18,622,663	0				10.00
SUMMARY OF CAPITAL							
Cost Center Description		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	509,845				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,135,511				2.00
2.01	CAP REL COSTS-MOB	0	368,310				2.01
3.00	Total (sum of lines 1-2)	0	2,013,666				3.00
ALLOCATION OF OTHER CAPITAL							
Cost Center Description		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	309,000	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	170,037	814,164	2.00
2.01	CAP REL COSTS-MOB	0	0	0	41,924	326,386	2.01
3.00	Total (sum of lines 1-2)	0	0	0	520,961	1,140,550	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151309

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
1/31/2012 8:54 am

Cost Center Description	SUMMARY OF CAPITAL					Total (2) (sum of cols. 9 through 14)	
	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
	11.00	12.00	13.00	14.00	15.00		
PART III -- RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	68,126	13,251	0	0	390,377	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	159,093	984	0	0	1,144,278	2.00
2.01	CAP REL COSTS-MOB	0	0	0	0	368,310	2.01
3.00	Total (sum of lines 1-2)	227,219	14,235	0	0	1,902,965	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)	B	-25,804	CAP REL COSTS-BLDG & FIXT	1.00 1.00
2.00	Investment income - movable equipment (chapter 2)	B	-50,447	CAP REL COSTS-MVBLE EQUIP	2.00 2.00
3.00	Investment income - other (chapter 2)		0		0.00 3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00 4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00 5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00 6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-9,000	ADMINISTRATIVE & GENERAL	5.00 7.00
8.00	Television and radio service (chapter 21)	A	-2,563	OPERATION OF PLANT	7.00 8.00
9.00	Parking lot (chapter 21)		0		0.00 9.00
10.00	Provider-based physician adjustment	A-8-2	-62,500		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	896,498		12.00
13.00	Laundry and linen service		0		0.00 13.00
14.00	Cafeteria-employees and guests	B	-36,089	CAFETERIA	11.00 14.00
15.00	Rental of quarters to employee and others		0		0.00 15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00 16.00
17.00	Sale of drugs to other than patients	B	-308	DRUGS CHARGED TO PATIENTS	73.00 17.00
18.00	Sale of medical records and abstracts		0		0.00 18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00 19.00
20.00	Vending machines		0		0.00 20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00 21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00 22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00 23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00 24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00 25.00
26.00	Depreciation - buildings and fixtures		0	CAP REL COSTS-BLDG & FIXT	1.00 26.00
27.00	Depreciation - movable equipment		0	CAP REL COSTS-MVBLE EQUIP	2.00 27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00 28.00
29.00	Physicians' assistant		0		0.00 29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	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	MISCELLANEOUS INCOME	B	-16,094	ADMINISTRATIVE & GENERAL	5.00 33.00
33.01	INTEREST	B	-28,211	ADMINISTRATIVE & GENERAL	5.00 33.01
33.02	LOBBYING	A	-777	ADMINISTRATIVE & GENERAL	5.00 33.02
33.03	NON-REIMBURSABLE ANESTHESIOLOGY	A	-327,139	ANESTHESIOLOGY	53.00 33.03
33.04	OTHER NON-REIMBURSABLE EXPENSE	A	-4,239	ADMINISTRATIVE & GENERAL	5.00 33.04
33.05	CSI SERVICING FEES	A	34,182	ADMINISTRATIVE & GENERAL	5.00 33.05
33.06	PHYSICIAN RECRUITMENT	A	-2,336	ADMINISTRATIVE & GENERAL	5.00 33.06
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200.)		365,173		50.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 151309

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

Worksheet A-8

Date/Time Prepared:
1/31/2012 8:54 am

		Wkst. A-7 Ref.	
		5.00	
1.00	Investment income - buildings and fixtures (chapter 2)	9	1.00
2.00	Investment income - movable equipment (chapter 2)	9	2.00
3.00	Investment income - other (chapter 2)	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	0	7.00
8.00	Television and radio service (chapter 21)	0	8.00
9.00	Parking lot (chapter 21)	0	9.00
10.00	Provider-based physician adjustment	0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	0	11.00
12.00	Related organization transactions (chapter 10)	0	12.00
13.00	Laundry and linen service	0	13.00
14.00	Cafeteria-employees and guests	0	14.00
15.00	Rental of quarters to employee and others	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	0	16.00
17.00	Sale of drugs to other than patients	0	17.00
18.00	Sale of medical records and abstracts	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)	0	19.00
20.00	Vending machines	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		25.00
26.00	Depreciation - buildings and fixtures	0	26.00
27.00	Depreciation - movable equipment	0	27.00
28.00	Non-physician Anesthetist		28.00
29.00	Physicians' assistant	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)		30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	0	32.00
33.00	MISCELLANEOUS INCOME	0	33.00
33.01	INTEREST	0	33.01
33.02	LOBBYING	0	33.02
33.03	NON-REIMBURSABLE ANESTHESIOLOGY	0	33.03
33.04	OTHER NON-REIMBURSABLE EXPENSE	0	33.04
33.05	CSI SERVICING FEES	0	33.05
33.06	PHYSICIAN RECRUITMENT	0	33.06
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: 151309

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

Worksheet A-8-1

Date/Time Prepared:
1/31/2012 8:54 am

	Line No.	Cost Center	Expense Items	
	1.00	2.00	3.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	2.00
3.00	4.00	EMPLOYEE BENEFITS	ST. VINCENT HOSPITAL - IN	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	ST. VINCENT HOSPITAL - IN	4.00
4.01	7.00	OPERATION OF PLANT	ST. VINCENT HOSPITAL - IN	4.01
4.02	14.00	CENTRAL SERVICES & SUPPLY	ST. VINCENT HOSPITAL - IN	4.02
4.03	16.00	MEDICAL RECORDS & LIBRARY	ST. VINCENT HOSPITAL - IN	4.03
4.04	50.00	OPERATING ROOM	ST. VINCENT HOSPITAL - IN	4.04
4.05	54.00	RADIOLOGY - DIAGNOSTIC	ST. VINCENT HOSPITAL - IN	4.05
4.06	91.00	EMERGENCY	ST. VINCENT HOSPITAL - IN	4.06
4.07	193.01	CLAY CITY MEDICAL CLINIC	ST. VINCENT HOSPITAL - IN	4.07
4.08	1.00	CAP REL COSTS-BLDG & FIXT	ASCENSION CHARGEBACK	4.08
4.09	2.00	CAP REL COSTS-MVBLE EQUIP	ASCENSION CHARGEBACK	4.09
4.10	4.00	EMPLOYEE BENEFITS	ASCENSION CHARGEBACK	4.10
4.11	5.00	ADMINISTRATIVE & GENERAL	ASCENSION CHARGEBACK	4.11
4.12	1.00	CAP REL COSTS-BLDG & FIXT	ASCENSION INTEREST	4.12
4.13	2.00	CAP REL COSTS-MVBLE EQUIP	ASCENSION INTEREST	4.13
4.14	5.00	ADMINISTRATIVE & GENERAL	ASCENSION INTEREST	4.14
4.15	5.00	ADMINISTRATIVE & GENERAL	ASCENSION - MAINTENANCE	4.15
4.16	4.00	EMPLOYEE BENEFITS	SELF INSURANCE	4.16
4.17	193.02	PUBLIC RELATIONS	MARKETING	4.17
4.18	4.00	EMPLOYEE BENEFITS	PENSION	4.18
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			5.00

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

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

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

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

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

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

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

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

Provider CCN: 151309

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

Worksheet A-8-1

Date/Time Prepared: 1/31/2012 8:54 am

	Amount of Allowable Cost	Amount Included in wks. A, column 5	Net Adjustments (col. 4 minus col. 5)*	wkst. A-7 Ref.	
	4.00	5.00	6.00	7.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	200,583	0	200,583	9	1.00
2.00	1,635,204	1,157,478	477,726	0	2.00
3.00	219,877	219,877	0	0	3.00
4.00	693,982	693,982	0	0	4.00
4.01	13,460	13,460	0	0	4.01
4.02	1,644	1,644	0	0	4.02
4.03	57,038	57,038	0	0	4.03
4.04	2,297	2,297	0	0	4.04
4.05	11,798	11,798	0	0	4.05
4.06	1,261	1,261	0	0	4.06
4.07	18,855	18,855	0	0	4.07
4.08	324,535	324,535	0	9	4.08
4.09	984	984	0	9	4.09
4.10	89,424	89,424	0	0	4.10
4.11	29,739	29,739	0	0	4.11
4.12	25,804	76,892	-51,088	9	4.12
4.13	50,447	150,326	-99,879	9	4.13
4.14	28,211	84,066	-55,855	0	4.14
4.15	250,105	268,814	-18,709	0	4.15
4.16	995,028	790,108	204,920	0	4.16
4.17	238,800	0	238,800	0	4.17
4.18	404,580	404,580	0	0	4.18
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to worksheet A-8, column 2, line 12.	5,293,656	4,397,158	896,498	5.00

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

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

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

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

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

6.00	ST. VINCENT HEA	100.00	ADMINISTRATION	6.00
7.00	ST. VINCENT HOS	100.00	HOSPITAL	7.00
8.00	ASCENSION	100.00	ADMINISTRATION	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: 151309

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

Worksheet A-8-2

Date/Time Prepared:
1/31/2012 8:54 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
	1.00	2.00	3.00	4.00	
1.00	91.00	EMERGENCY	403,317	0	1.00
2.00	91.00	EMERGENCY	62,500	62,500	2.00
3.00	0.00		0	0	3.00
4.00	0.00		0	0	4.00
5.00	0.00		0	0	5.00
6.00	0.00		0	0	6.00
7.00	0.00		0	0	7.00
8.00	0.00		0	0	8.00
9.00	0.00		0	0	9.00
10.00	0.00		0	0	10.00
200.00		TOTAL (lines 1.00 through 199.00)	465,817	62,500	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151309

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

Worksheet A-8-2

Date/Time Prepared:
1/31/2012 8:54 am

	Provider Component	RCE Amount	Physician/Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	5.00	6.00	7.00	8.00	9.00	
1.00	403,317	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	403,317		0	0	0	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151309

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

Worksheet A-8-2

Date/Time Prepared:
1/31/2012 8:54 am

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151309

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

Worksheet A-8-2

Date/Time Prepared:
1/31/2012 8:54 am

	RCE Disallowance	Adjustment	
	17.00	18.00	
1.00	0	0	1.00
2.00	0	62,500	2.00
3.00	0	0	3.00
4.00	0	0	4.00
5.00	0	0	5.00
6.00	0	0	6.00
7.00	0	0	7.00
8.00	0	0	8.00
9.00	0	0	9.00
10.00	0	0	10.00
200.00	0	62,500	200.00

		Physical Therapy					Cost	
							1.00	
PART I - GENERAL INFORMATION								
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00	
2.00	Line 1 multiplied by 15 hours per week					780	2.00	
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					555	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)					8	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					5.50	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	1,625.00	3,795.00	4,438.00	4,732.00	0.00	9.00	
10.00	AHSEA (see instructions)	84.25	73.26	54.94	48.84	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	27.47			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	
Part II - SALARY EQUIVALENCY COMPUTATION								
14.00	Supervisors (column 1, line 9 times column 1, line 10)					136,906	14.00	
15.00	Therapists (column 2, line 9 times column 2, line 10)					278,022	15.00	
16.00	Assistants (column 3, line 9 times column 3, line 10)					243,824	16.00	
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					658,752	17.00	
18.00	Aides (column 4, line 9 times column 4, line 10)					231,111	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)					889,863	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)					889,863	23.00	
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE								
Standard Travel Allowance								
24.00	Therapists (line 3 times column 2, line 11)					20,330	24.00	
25.00	Assistants (line 4 times column 3, line 11)					220	25.00	
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					20,550	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)					3,097	27.00	
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					23,647	28.00	
Optional Travel Allowance and Optional Travel Expense								
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00	
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00	
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00	
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00	
33.00	Standard travel allowance and standard travel expense (line 28)					23,647	33.00	
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00	
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00	
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE								
Standard Travel Expense								
36.00	Therapists (line 5 times column 2, line 11)					0	36.00	
37.00	Assistants (line 6 times column 3, line 11)					0	37.00	
38.00	Subtotal (sum of lines 36 and 37)					0	38.00	
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00	
Optional Travel Allowance and Optional Travel Expense								
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00	
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00	
42.00	Subtotal (sum of lines 40 and 41)					0	42.00	
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00	
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.								
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00	

		Physical Therapy				Cost	
						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
PART V - OVERTIME COMPUTATION							
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00	0.00	48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00	0.00	49.00
CALCULATION OF LIMIT							
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
DETERMINATION OF OVERTIME ALLOWANCE							
52.00	Adjusted hourly salary equivalency amount (see instructions)	73.26	54.94	48.84	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	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		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00
						1.00	
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT							
57.00	Salary equivalency amount (from line 23)					889,863	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35)					23,647	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)					913,510	63.00
64.00	Total cost of outside supplier services (from your records)					562,603	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					20,550	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					3,097	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27					23,647	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					3,097	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					3,097	101.02
LINE 35 CALCULATION							
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others					0	102.01
102.02	Line 35 = sum of lines 31 and 32					0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 151309	Period: From 07/01/2010 To 06/30/2011	Worksheet A-8-3 Par
			Date/Time Prepared: 1/31/2012 8:54 am
		Speech Pathology	Cost

							1.00	
PART I - GENERAL INFORMATION								
1.00	Total number of weeks worked (excluding aides) (see instructions)					0	1.00	
2.00	Line 1 multiplied by 15 hours per week					0	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					0.00	7.00	
8.00	Optional travel expense rate per mile					0.00	8.00	
		Supervisors	Therapists	Assistants	Aides	Trainees		
		1.00	2.00	3.00	4.00	5.00		
9.00	Total hours worked	0.00	0.00	0.00	0.00	0.00	9.00	
10.00	AHSEA (see instructions)	0.00	0.00	0.00	0.00	0.00	10.00	
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	0.00	0.00	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	
Part II - SALARY EQUIVALENCY COMPUTATION								
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00	
15.00	Therapists (column 2, line 9 times column 2, line 10)					0	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)					0	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)					0	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)					0	23.00	
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE								
Standard Travel Allowance								
24.00	Therapists (line 3 times column 2, line 11)					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	
Optional Travel Allowance and Optional Travel Expense								
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00	
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00	
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00	
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00	
33.00	Standard travel allowance and standard travel expense (line 28)					0	33.00	
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00	
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00	
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE								
Standard Travel Expense								
36.00	Therapists (line 5 times column 2, line 11)					0	36.00	
37.00	Assistants (line 6 times column 3, line 11)					0	37.00	
38.00	Subtotal (sum of lines 36 and 37)					0	38.00	
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00	
Optional Travel Allowance and Optional Travel Expense								
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00	
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00	
42.00	Subtotal (sum of lines 40 and 41)					0	42.00	
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00	
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.								
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00	

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 151309	Period: From 07/01/2010 To 06/30/2011	Worksheet A-8-3 Par Date/Time Prepared: 1/31/2012 8:54 am
		Speech Pathology	Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
PART V - OVERTIME COMPUTATION							
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00	0.00	48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00	0.00	49.00
CALCULATION OF LIMIT							
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
DETERMINATION OF OVERTIME ALLOWANCE							
52.00	Adjusted hourly salary equivalency amount (see instructions)	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	53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0	0	54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0	0	55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00
						1.00	
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT							
57.00	Salary equivalency amount (from line 23)					0	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)					0	63.00
64.00	Total cost of outside supplier services (from your records)					0	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: 151309

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

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description	Net Expenses for Cost Allocation (from wkst A col. 7)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS	
		BLDG & FIXT	MVBLE EQUIP	MOB		
	0	1.00	2.00	2.01	4.00	
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	390,377	390,377			1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,144,278		1,144,278		2.00
2.01	CAP REL COSTS-MOB	368,310			368,310	2.01
4.00	EMPLOYEE BENEFITS	2,549,890	0	0	0	4.00
5.00	ADMINISTRATIVE & GENERAL	3,749,391	129,653	371,958	18,360	5.00
7.00	OPERATION OF PLANT	777,070	80,113	229,833	0	7.00
8.00	LAUNDRY & LINEN SERVICE	57,302	8,373	24,022	0	8.00
9.00	HOUSEKEEPING	270,360	4,643	13,322	0	9.00
10.00	DIETARY	148,491	10,314	29,590	0	10.00
11.00	CAFETERIA	113,295	5,850	16,784	0	11.00
13.00	NURSING ADMINISTRATION	367,021	1,278	3,666	0	13.00
14.00	CENTRAL SERVICES & SUPPLY	11,942	7,086	20,329	0	14.00
15.00	PHARMACY	408,479	4,582	13,145	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	263,829	40,622	116,539	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,066,104	26,370	75,651	0	30.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	623,610	10,825	31,056	0	50.00
53.00	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	RADIOLOGY - DIAGNOSTIC	896,684	7,507	21,537	0	54.00
60.00	LABORATORY	1,078,407	6,139	17,613	14,673	60.00
65.00	RESPIRATORY THERAPY	205,790	7,403	21,238	0	65.00
66.00	PHYSICAL THERAPY	571,088	7,862	22,556	43,318	66.00
68.00	SPEECH PATHOLOGY	3,959	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	103,643	0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	2,594	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	773,808	0	0	0	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	200,353	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	834,076	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
91.00	EMERGENCY	1,319,941	21,722	62,316	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	18,300,092	380,342	1,091,155	76,351	118.00
NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	1,003	2,879	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	37,763	0	0	291,959	192.00
193.00	NONPAID WORKERS	0	0	0	0	193.00
193.01	CLAY CITY MEDICAL CLINIC	292,156	0	24,334	0	193.01
193.02	PUBLIC RELATIONS	261,723	237	679	0	193.02
193.03	FOUNDATION	13,980	0	0	0	193.03
193.04	MISSION SERVICES	2,714	0	0	0	193.04
193.05	OTHER NON-REIMBURSABLE	0	8,795	25,231	0	193.05
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	18,908,428	390,377	1,144,278	368,310	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151309

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

Worksheet B
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Cost Center Description		Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		4A	5.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	CAP REL COSTS-MOB						2.01
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL	4,893,058	4,893,058				5.00
7.00	OPERATION OF PLANT	1,207,497	421,563	1,629,060			7.00
8.00	LAUNDRY & LINEN SERVICE	89,697	31,315	68,546	189,558		8.00
9.00	HOUSEKEEPING	370,427	129,324	38,012	5,958	543,721	9.00
10.00	DIETARY	229,728	80,203	84,433	2,708	17,307	10.00
11.00	CAFETERIA	177,511	61,973	47,893	0	3,606	11.00
13.00	NURSING ADMINISTRATION	494,513	172,645	10,462	0	25,239	13.00
14.00	CENTRAL SERVICES & SUPPLY	39,357	13,740	58,006	0	0	14.00
15.00	PHARMACY	426,206	148,797	37,508	0	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	513,596	179,307	332,540	0	6,490	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	1,542,299	538,449	215,867	68,561	161,529	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	848,747	296,315	88,618	29,104	49,757	50.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY - DIAGNOSTIC	1,167,207	407,496	61,455	23,249	28,845	54.00
60.00	LABORATORY	1,253,469	437,612	88,346	0	39,661	60.00
65.00	RESPIRATORY THERAPY	306,360	106,957	60,602	0	0	65.00
66.00	PHYSICAL THERAPY	644,824	225,122	176,809	5,646	43,267	66.00
68.00	SPEECH PATHOLOGY	4,204	1,468	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	137,695	48,072	0	0	14,422	69.00
70.00	ELECTROENCEPHALOGRAPHY	3,584	1,251	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	773,808	270,153	0	0	0	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	200,353	69,947	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	834,076	291,193	0	0	10,817	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	EMERGENCY	1,707,115	595,989	177,816	54,332	142,781	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	17,865,331	4,528,891	1,546,913	189,558	543,721	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	3,882	1,355	8,215	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	329,722	115,113	0	0	0	192.00
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	CLAY CITY MEDICAL CLINIC	387,668	135,343	0	0	0	193.01
193.02	PUBLIC RELATIONS	271,105	94,648	1,937	0	0	193.02
193.03	FOUNDATION	13,980	4,881	0	0	0	193.03
193.04	MISSION SERVICES	2,714	948	0	0	0	193.04
193.05	OTHER NON-REIMBURSABLE	34,026	11,879	71,995	0	0	193.05
200.00	Cross Foot Adjustments	0	0	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	18,908,428	4,893,058	1,629,060	189,558	543,721	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151309

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

Worksheet B
Part I
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Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	CAP REL COSTS-MOB						2.01
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
7.00	OPERATION OF PLANT						7.00
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING						9.00
10.00	DIETARY	414,379					10.00
11.00	CAFETERIA	0	290,983				11.00
13.00	NURSING ADMINISTRATION	0	17,898	720,757			13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	0	111,103		14.00
15.00	PHARMACY	0	0	0	0	612,511	15.00
16.00	MEDICAL RECORDS & LIBRARY	0	26,949	0	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	414,379	68,915	316,684	0	0	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	0	38,712	177,892	0	0	50.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY - DIAGNOSTIC	0	40,814	0	0	0	54.00
60.00	LABORATORY	0	27,051	0	0	0	60.00
65.00	RESPIRATORY THERAPY	0	14,136	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	0	0	0	66.00
68.00	SPEECH PATHOLOGY	0	34	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	5,288	0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	271	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	111,103	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	612,511	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	EMERGENCY	0	49,220	226,181	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	414,379	289,288	720,757	111,103	612,511	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	CLAY CITY MEDICAL CLINIC	0	0	0	0	0	193.01
193.02	PUBLIC RELATIONS	0	1,695	0	0	0	193.02
193.03	FOUNDATION	0	0	0	0	0	193.03
193.04	MISSION SERVICES	0	0	0	0	0	193.04
193.05	OTHER NON-REIMBURSABLE	0	0	0	0	0	193.05
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)	414,379	290,983	720,757	111,103	612,511	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151309

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

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Part I
Date/Time Prepared:
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Cost Center Description		MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		16.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
2.01	CAP REL COSTS-MOB					2.01
4.00	EMPLOYEE BENEFITS					4.00
5.00	ADMINISTRATIVE & GENERAL					5.00
7.00	OPERATION OF PLANT					7.00
8.00	LAUNDRY & LINEN SERVICE					8.00
9.00	HOUSEKEEPING					9.00
10.00	DIETARY					10.00
11.00	CAFETERIA					11.00
13.00	NURSING ADMINISTRATION					13.00
14.00	CENTRAL SERVICES & SUPPLY					14.00
15.00	PHARMACY					15.00
16.00	MEDICAL RECORDS & LIBRARY	1,058,882				16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	44,731	3,371,414	0	3,371,414	30.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	114,438	1,643,583	0	1,643,583	50.00
53.00	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	RADIOLOGY - DIAGNOSTIC	281,115	2,010,181	0	2,010,181	54.00
60.00	LABORATORY	181,407	2,027,546	0	2,027,546	60.00
65.00	RESPIRATORY THERAPY	12,855	500,910	0	500,910	65.00
66.00	PHYSICAL THERAPY	49,913	1,145,581	0	1,145,581	66.00
68.00	SPEECH PATHOLOGY	5	5,711	0	5,711	68.00
69.00	ELECTROCARDIOLOGY	36,418	241,895	0	241,895	69.00
70.00	ELECTROENCEPHALOGRAPHY	829	5,935	0	5,935	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	54,365	1,209,429	0	1,209,429	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	12,285	282,585	0	282,585	72.00
73.00	DRUGS CHARGED TO PATIENTS	92,165	1,840,762	0	1,840,762	73.00
OUTPATIENT SERVICE COST CENTERS						
91.00	EMERGENCY	178,356	3,131,790	0	3,131,790	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)			0		92.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	1,058,882	17,417,322	0	17,417,322	118.00
NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	13,452	0	13,452	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	444,835	0	444,835	192.00
193.00	NONPAID WORKERS	0	0	0	0	193.00
193.01	CLAY CITY MEDICAL CLINIC	0	523,011	0	523,011	193.01
193.02	PUBLIC RELATIONS	0	369,385	0	369,385	193.02
193.03	FOUNDATION	0	18,861	0	18,861	193.03
193.04	MISSION SERVICES	0	3,662	0	3,662	193.04
193.05	OTHER NON-REIMBURSABLE	0	117,900	0	117,900	193.05
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)	1,058,882	18,908,428	0	18,908,428	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151309

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

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS			Subtotal	
		BLDG & FIXT	MVBLE EQUIP	MOB		
		0	1.00	2.00		2.01
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT				1.00	
2.00	CAP REL COSTS-MVBLE EQUIP				2.00	
2.01	CAP REL COSTS-MOB				2.01	
4.00	EMPLOYEE BENEFITS	0	0	0	0	
5.00	ADMINISTRATIVE & GENERAL	0	129,653	371,958	18,360	519,971
7.00	OPERATION OF PLANT	0	80,113	229,833	0	309,946
8.00	LAUNDRY & LINEN SERVICE	0	8,373	24,022	0	32,395
9.00	HOUSEKEEPING	0	4,643	13,322	0	17,965
10.00	DIETARY	0	10,314	29,590	0	39,904
11.00	CAFETERIA	0	5,850	16,784	0	22,634
13.00	NURSING ADMINISTRATION	0	1,278	3,666	0	4,944
14.00	CENTRAL SERVICES & SUPPLY	0	7,086	20,329	0	27,415
15.00	PHARMACY	0	4,582	13,145	0	17,727
16.00	MEDICAL RECORDS & LIBRARY	0	40,622	116,539	0	157,161
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	0	26,370	75,651	0	102,021
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	10,825	31,056	0	41,881
53.00	ANESTHESIOLOGY	0	0	0	0	0
54.00	RADIOLOGY - DIAGNOSTIC	0	7,507	21,537	0	29,044
60.00	LABORATORY	0	6,139	17,613	14,673	38,425
65.00	RESPIRATORY THERAPY	0	7,403	21,238	0	28,641
66.00	PHYSICAL THERAPY	0	7,862	22,556	43,318	73,736
68.00	SPEECH PATHOLOGY	0	0	0	0	0
69.00	ELECTROCARDIOLOGY	0	0	0	0	0
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS						
91.00	EMERGENCY	0	21,722	62,316	0	84,038
92.00	OBSERVATION BEDS (NON-DISTINCT PART)					0
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	380,342	1,091,155	76,351	1,547,848
NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	1,003	2,879	0	3,882
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	291,959	291,959
193.00	NONPAID WORKERS	0	0	0	0	0
193.01	CLAY CITY MEDICAL CLINIC	0	0	24,334	0	24,334
193.02	PUBLIC RELATIONS	0	237	679	0	916
193.03	FOUNDATION	0	0	0	0	0
193.04	MISSION SERVICES	0	0	0	0	0
193.05	OTHER NON-REIMBURSABLE	0	8,795	25,231	0	34,026
200.00	Cross Foot Adjustments					0
201.00	Negative Cost Centers					0
202.00	TOTAL (sum lines 118-201)	0	390,377	1,144,278	368,310	1,902,965

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151309

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

Worksheet B
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Cost Center Description		EMPLOYEE BENEFITS	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		4.00	5.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	CAP REL COSTS-MOB						2.01
4.00	EMPLOYEE BENEFITS	0					4.00
5.00	ADMINISTRATIVE & GENERAL	0	519,971				5.00
7.00	OPERATION OF PLANT	0	44,798	354,744			7.00
8.00	LAUNDRY & LINEN SERVICE	0	3,328	14,927	50,650		8.00
9.00	HOUSEKEEPING	0	13,743	8,278	1,592	41,578	9.00
10.00	DIETARY	0	8,523	18,386	723	1,323	10.00
11.00	CAFETERIA	0	6,586	10,429	0	276	11.00
13.00	NURSING ADMINISTRATION	0	18,346	2,278	0	1,930	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	1,460	12,631	0	0	14.00
15.00	PHARMACY	0	15,812	8,168	0	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	0	19,054	72,414	0	496	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	0	57,219	47,007	18,320	12,352	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	0	31,489	19,297	7,777	3,805	50.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY - DIAGNOSTIC	0	43,303	13,382	6,212	2,206	54.00
60.00	LABORATORY	0	46,504	19,238	0	3,033	60.00
65.00	RESPIRATORY THERAPY	0	11,366	13,197	0	0	65.00
66.00	PHYSICAL THERAPY	0	23,923	38,502	1,508	3,309	66.00
68.00	SPEECH PATHOLOGY	0	156	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	5,108	0	0	1,103	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	133	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	28,708	0	0	0	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	7,433	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	30,944	0	0	827	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	EMERGENCY	0	63,336	38,721	14,518	10,918	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	481,272	336,855	50,650	41,578	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	144	1,789	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	12,233	0	0	0	192.00
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	CLAY CITY MEDICAL CLINIC	0	14,382	0	0	0	193.01
193.02	PUBLIC RELATIONS	0	10,058	422	0	0	193.02
193.03	FOUNDATION	0	519	0	0	0	193.03
193.04	MISSION SERVICES	0	101	0	0	0	193.04
193.05	OTHER NON-REIMBURSABLE	0	1,262	15,678	0	0	193.05
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	519,971	354,744	50,650	41,578	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151309

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

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
	10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS						
1.00						1.00
2.00						2.00
2.01						2.01
4.00						4.00
5.00						5.00
7.00						7.00
8.00						8.00
9.00						9.00
10.00	68,859					10.00
11.00	0	39,925				11.00
13.00	0	2,456	29,954			13.00
14.00	0	0	0	41,506		14.00
15.00	0	0	0	0	41,707	15.00
16.00	0	3,698	0	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	68,859	9,453	13,161	0	0	30.00
ANCILLARY SERVICE COST CENTERS						
50.00	0	5,312	7,393	0	0	50.00
53.00	0	0	0	0	0	53.00
54.00	0	5,600	0	0	0	54.00
60.00	0	3,712	0	0	0	60.00
65.00	0	1,940	0	0	0	65.00
66.00	0	0	0	0	0	66.00
68.00	0	5	0	0	0	68.00
69.00	0	726	0	0	0	69.00
70.00	0	37	0	0	0	70.00
71.00	0	0	0	41,506	0	71.00
72.00	0	0	0	0	0	72.00
73.00	0	0	0	0	41,707	73.00
OUTPATIENT SERVICE COST CENTERS						
91.00	0	6,753	9,400	0	0	91.00
92.00						92.00
SPECIAL PURPOSE COST CENTERS						
118.00	68,859	39,692	29,954	41,506	41,707	118.00
NONREIMBURSABLE COST CENTERS						
190.00	0	0	0	0	0	190.00
192.00	0	0	0	0	0	192.00
193.00	0	0	0	0	0	193.00
193.01	0	0	0	0	0	193.01
193.02	0	233	0	0	0	193.02
193.03	0	0	0	0	0	193.03
193.04	0	0	0	0	0	193.04
193.05	0	0	0	0	0	193.05
200.00						200.00
201.00	0	0	0	0	0	201.00
202.00	68,859	39,925	29,954	41,506	41,707	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151309

Period:
From 07/01/2010
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Worksheet B
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Cost Center Description		MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
GENERAL SERVICE COST CENTERS		16.00	24.00	25.00	26.00	
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
2.01	CAP REL COSTS-MOB					2.01
4.00	EMPLOYEE BENEFITS					4.00
5.00	ADMINISTRATIVE & GENERAL					5.00
7.00	OPERATION OF PLANT					7.00
8.00	LAUNDRY & LINEN SERVICE					8.00
9.00	HOUSEKEEPING					9.00
10.00	DIETARY					10.00
11.00	CAFETERIA					11.00
13.00	NURSING ADMINISTRATION					13.00
14.00	CENTRAL SERVICES & SUPPLY					14.00
15.00	PHARMACY					15.00
16.00	MEDICAL RECORDS & LIBRARY	252,823				16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	10,681	339,073	0	339,073	30.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	27,326	144,280	0	144,280	50.00
53.00	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	RADIOLOGY - DIAGNOSTIC	67,105	166,852	0	166,852	54.00
60.00	LABORATORY	43,317	154,229	0	154,229	60.00
65.00	RESPIRATORY THERAPY	3,069	58,213	0	58,213	65.00
66.00	PHYSICAL THERAPY	11,919	152,897	0	152,897	66.00
68.00	SPEECH PATHOLOGY	1	162	0	162	68.00
69.00	ELECTROCARDIOLOGY	8,696	15,633	0	15,633	69.00
70.00	ELECTROENCEPHALOGRAPHY	198	368	0	368	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	12,981	83,195	0	83,195	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	2,933	10,366	0	10,366	72.00
73.00	DRUGS CHARGED TO PATIENTS	22,008	95,486	0	95,486	73.00
OUTPATIENT SERVICE COST CENTERS						
91.00	EMERGENCY	42,589	270,273	0	270,273	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)			0		92.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	252,823	1,491,027	0	1,491,027	118.00
NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	5,815	0	5,815	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	304,192	0	304,192	192.00
193.00	NONPAID WORKERS	0	0	0	0	193.00
193.01	CLAY CITY MEDICAL CLINIC	0	38,716	0	38,716	193.01
193.02	PUBLIC RELATIONS	0	11,629	0	11,629	193.02
193.03	FOUNDATION	0	519	0	519	193.03
193.04	MISSION SERVICES	0	101	0	101	193.04
193.05	OTHER NON-REIMBURSABLE	0	50,966	0	50,966	193.05
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)	252,823	1,902,965	0	1,902,965	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151309

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	
	BLDG & FIXT (SQARE FEET)	MVBLE EQUIP (SQARE FEET)	MOB (SQARE FEET)			
	1.00	2.00	2.01			
GENERAL SERVICE COST CENTERS						
1.00	82,473					1.00
2.00		84,265				2.00
2.01		0	24,674			2.01
4.00	0	0	0	6,679,609		4.00
5.00	27,391	27,391	1,230	1,633,806	-4,893,058	5.00
7.00	16,925	16,925	0	315,608	0	7.00
8.00	1,769	1,769	0	0	0	8.00
9.00	981	981	0	215,071	0	9.00
10.00	2,179	2,179	0	108,276	0	10.00
11.00	1,236	1,236	0	108,928	0	11.00
13.00	270	270	0	321,022	0	13.00
14.00	1,497	1,497	0	0	0	14.00
15.00	968	968	0	0	0	15.00
16.00	8,582	8,582	0	242,588	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	5,571	5,571	0	980,175	0	30.00
ANCILLARY SERVICE COST CENTERS						
50.00	2,287	2,287	0	480,052	0	50.00
53.00	0	0	0	0	0	53.00
54.00	1,586	1,586	0	632,572	0	54.00
60.00	1,297	1,297	983	357,930	0	60.00
65.00	1,564	1,564	0	188,423	0	65.00
66.00	1,661	1,661	2,902	0	0	66.00
68.00	0	0	0	643	0	68.00
69.00	0	0	0	89,202	0	69.00
70.00	0	0	0	2,594	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
OUTPATIENT SERVICE COST CENTERS						
91.00	4,589	4,589	0	794,086	0	91.00
92.00						92.00
SPECIAL PURPOSE COST CENTERS						
118.00	80,353	80,353	5,115	6,470,976	-4,893,058	118.00
NONREIMBURSABLE COST CENTERS						
190.00	212	212	0	0	0	190.00
192.00	0	0	19,559	0	0	192.00
193.00	0	0	0	0	0	193.00
193.01	0	1,792	0	186,457	0	193.01
193.02	50	50	0	22,176	0	193.02
193.03	0	0	0	0	0	193.03
193.04	0	0	0	0	0	193.04
193.05	1,858	1,858	0	0	0	193.05
200.00						200.00
201.00						201.00
202.00	390,377	1,144,278	368,310	2,549,890		202.00
203.00	4.733392	13.579517	14.927049	0.381742		203.00
204.00				0		204.00
205.00				0.000000		205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151309

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
	5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS						
1.00						1.00
2.00						2.00
2.01						2.01
4.00						4.00
5.00	14,015,370					5.00
7.00	1,207,497	42,042				7.00
8.00	89,697	1,769	124,200			8.00
9.00	370,427	981	3,904	754		9.00
10.00	229,728	2,179	1,774	24	100	10.00
11.00	177,511	1,236	0	5	0	11.00
13.00	494,513	270	0	35	0	13.00
14.00	39,357	1,497	0	0	0	14.00
15.00	426,206	968	0	0	0	15.00
16.00	513,596	8,582	0	9	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	1,542,299	5,571	44,922	224	100	30.00
ANCILLARY SERVICE COST CENTERS						
50.00	848,747	2,287	19,069	69	0	50.00
53.00	0	0	0	0	0	53.00
54.00	1,167,207	1,586	15,233	40	0	54.00
60.00	1,253,469	2,280	0	55	0	60.00
65.00	306,360	1,564	0	0	0	65.00
66.00	644,824	4,563	3,699	60	0	66.00
68.00	4,204	0	0	0	0	68.00
69.00	137,695	0	0	20	0	69.00
70.00	3,584	0	0	0	0	70.00
71.00	773,808	0	0	0	0	71.00
72.00	200,353	0	0	0	0	72.00
73.00	834,076	0	0	15	0	73.00
OUTPATIENT SERVICE COST CENTERS						
91.00	1,707,115	4,589	35,599	198	0	91.00
92.00						92.00
SPECIAL PURPOSE COST CENTERS						
118.00	12,972,273	39,922	124,200	754	100	118.00
NONREIMBURSABLE COST CENTERS						
190.00	3,882	212	0	0	0	190.00
192.00	329,722	0	0	0	0	192.00
193.00	0	0	0	0	0	193.00
193.01	387,668	0	0	0	0	193.01
193.02	271,105	50	0	0	0	193.02
193.03	13,980	0	0	0	0	193.03
193.04	2,714	0	0	0	0	193.04
193.05	34,026	1,858	0	0	0	193.05
200.00						200.00
201.00						201.00
202.00	4,893,058	1,629,060	189,558	543,721	414,379	202.00
203.00	0.349121	38.748394	1.526232	721.115385	4,143.790000	203.00
204.00	519,971	354,744	50,650	41,578	68,859	204.00
205.00	0.037100	8.437848	0.407810	55.143236	688.590000	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151309

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		CAFETERIA (HOURS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	CAP REL COSTS-MOB						2.01
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
7.00	OPERATION OF PLANT						7.00
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING						9.00
10.00	DIETARY						10.00
11.00	CAFETERIA	8,584					11.00
13.00	NURSING ADMINISTRATION	528	4,627				13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	100			14.00
15.00	PHARMACY	0	0	0	100		15.00
16.00	MEDICAL RECORDS & LIBRARY	795	0	0	0	53,558,321	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	2,033	2,033	0	0	2,262,475	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	1,142	1,142	0	0	5,788,192	50.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY - DIAGNOSTIC	1,204	0	0	0	14,219,487	54.00
60.00	LABORATORY	798	0	0	0	9,175,402	60.00
65.00	RESPIRATORY THERAPY	417	0	0	0	650,177	65.00
66.00	PHYSICAL THERAPY	0	0	0	0	2,524,578	66.00
68.00	SPEECH PATHOLOGY	1	0	0	0	230	68.00
69.00	ELECTROCARDIOLOGY	156	0	0	0	1,842,014	69.00
70.00	ELECTROENCEPHALOGRAPHY	8	0	0	0	41,946	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	100	0	2,749,712	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	621,372	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	100	4,661,636	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	EMERGENCY	1,452	1,452	0	0	9,021,100	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	8,534	4,627	100	100	53,558,321	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	CLAY CITY MEDICAL CLINIC	0	0	0	0	0	193.01
193.02	PUBLIC RELATIONS	50	0	0	0	0	193.02
193.03	FOUNDATION	0	0	0	0	0	193.03
193.04	MISSION SERVICES	0	0	0	0	0	193.04
193.05	OTHER NON-REIMBURSABLE	0	0	0	0	0	193.05
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)	290,983	720,757	111,103	612,511	1,058,882	202.00
203.00	Unit cost multiplier (wkst. B, Part I)	33.898299	155.771990	1,111.030000	6,125.110000	0.019771	203.00
204.00	Cost to be allocated (per wkst. B, Part II)	39,925	29,954	41,506	41,707	252,823	204.00
205.00	Unit cost multiplier (wkst. B, Part II)	4.651095	6.473741	415.060000	417.070000	0.004721	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151309

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

Worksheet C
Part I
Date/Time Prepared:
1/31/2012 8:54 am

		Title XVIII		Hospital		Cost	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE		Total Costs	
				Disallowance			
1.00	2.00	3.00	4.00	5.00			
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS		3,371,414		0		30.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM		1,643,583		0		50.00
53.00	ANESTHESIOLOGY		0		0		53.00
54.00	RADIOLOGY - DIAGNOSTIC		2,010,181		0		54.00
60.00	LABORATORY		2,027,546		0		60.00
65.00	RESPIRATORY THERAPY	0	500,910		0		65.00
66.00	PHYSICAL THERAPY	0	1,145,581		0		66.00
68.00	SPEECH PATHOLOGY	0	5,711		0		68.00
69.00	ELECTROCARDIOLOGY		241,895		0		69.00
70.00	ELECTROENCEPHALOGRAPHY		5,935		0		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS		1,209,429		0		71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS		282,585		0		72.00
73.00	DRUGS CHARGED TO PATIENTS		1,840,762		0		73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	EMERGENCY		3,131,790		0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)		535,325		0		92.00
200.00	Subtotal (see instructions)	0	17,952,647		0		200.00
201.00	Less Observation Beds		535,325		0		201.00
202.00	Total (see instructions)	0	17,417,322		0		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 151309	Period: From 07/01/2010 To 06/30/2011	Worksheet C Part I Date/Time Prepared: 1/31/2012 8:54 am
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Cost Center Description	Charges			Hospital Cost or Other Ratio	TEFRA Inpatient Ratio	Cost
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	2,262,475		2,262,475			30.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	526,690	5,261,502	5,788,192	0.283954	0.000000	50.00
53.00 ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00 RADIOLOGY - DIAGNOSTIC	843,013	13,376,474	14,219,487	0.141368	0.000000	54.00
60.00 LABORATORY	888,659	8,286,742	9,175,401	0.220976	0.000000	60.00
65.00 RESPIRATORY THERAPY	458,345	191,832	650,177	0.770421	0.000000	65.00
66.00 PHYSICAL THERAPY	498,763	2,025,815	2,524,578	0.453771	0.000000	66.00
68.00 SPEECH PATHOLOGY	230	0	230	24.830435	0.000000	68.00
69.00 ELECTROCARDIOLOGY	393,674	1,448,340	1,842,014	0.131321	0.000000	69.00
70.00 ELECTROENCEPHALOGRAPHY	7,175	34,771	41,946	0.141491	0.000000	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	744,626	2,005,085	2,749,711	0.439839	0.000000	71.00
72.00 IMPLANTABLE DEVICES CHARGED TO PATIENTS	396,470	224,902	621,372	0.454776	0.000000	72.00
73.00 DRUGS CHARGED TO PATIENTS	1,405,678	3,255,959	4,661,637	0.394875	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS						
91.00 EMERGENCY	257,381	8,763,718	9,021,099	0.347163	0.000000	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	477,316	477,316	1.121532	0.000000	92.00
200.00 Subtotal (see instructions)	8,683,179	45,352,456	54,035,635			200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	8,683,179	45,352,456	54,035,635			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 151309	Period: From 07/01/2010 To 06/30/2011	Worksheet C Part I Date/Time Prepared: 1/31/2012 8:54 am
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Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.000000			50.00
53.00	ANESTHESIOLOGY	0.000000			53.00
54.00	RADIOLOGY - DIAGNOSTIC	0.000000			54.00
60.00	LABORATORY	0.000000			60.00
65.00	RESPIRATORY THERAPY	0.000000			65.00
66.00	PHYSICAL THERAPY	0.000000			66.00
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
OUTPATIENT SERVICE COST CENTERS					
91.00	EMERGENCY	0.000000			91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151309

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

Worksheet C
Part I
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Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Title XIX		Hospital		Total Costs	
			Costs		Cost			
			Total Costs	RCE Disallowance	Total Costs			
	1.00	2.00	3.00	4.00	5.00			
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS		3,371,414		3,371,414	0	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	OPERATING ROOM		1,643,583		1,643,583	0	0	50.00
53.00	ANESTHESIOLOGY		0		0	0	0	53.00
54.00	RADIOLOGY - DIAGNOSTIC		2,010,181		2,010,181	0	0	54.00
60.00	LABORATORY		2,027,546		2,027,546	0	0	60.00
65.00	RESPIRATORY THERAPY	0	500,910		500,910	0	0	65.00
66.00	PHYSICAL THERAPY	0	1,145,581		1,145,581	0	0	66.00
68.00	SPEECH PATHOLOGY	0	5,711		5,711	0	0	68.00
69.00	ELECTROCARDIOLOGY		241,895		241,895	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY		5,935		5,935	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS		1,209,429		1,209,429	0	0	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS		282,585		282,585	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS		1,840,762		1,840,762	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
91.00	EMERGENCY		3,131,790		3,131,790	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)		538,299		538,299	0	0	92.00
200.00	Subtotal (see instructions)	0	17,955,621		17,955,621	0	0	200.00
201.00	Less Observation Beds		538,299		538,299	0	0	201.00
202.00	Total (see instructions)	0	17,417,322		17,417,322	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151309

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

Worksheet C
Part I
Date/Time Prepared:
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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		
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	2,262,475	2,262,475			30.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	526,690	5,261,502	5,788,192	0.283954	0.000000 50.00
53.00	ANESTHESIOLOGY	0	0	0	0.000000	0.000000 53.00
54.00	RADIOLOGY - DIAGNOSTIC	843,013	13,376,474	14,219,487	0.141368	0.000000 54.00
60.00	LABORATORY	888,659	8,286,742	9,175,401	0.220976	0.000000 60.00
65.00	RESPIRATORY THERAPY	458,345	191,832	650,177	0.770421	0.000000 65.00
66.00	PHYSICAL THERAPY	498,763	2,025,815	2,524,578	0.453771	0.000000 66.00
68.00	SPEECH PATHOLOGY	230	0	230	24.830435	0.000000 68.00
69.00	ELECTROCARDIOLOGY	393,674	1,448,340	1,842,014	0.131321	0.000000 69.00
70.00	ELECTROENCEPHALOGRAPHY	7,175	34,771	41,946	0.141491	0.000000 70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	744,626	2,005,085	2,749,711	0.439839	0.000000 71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	396,470	224,902	621,372	0.454776	0.000000 72.00
73.00	DRUGS CHARGED TO PATIENTS	1,405,678	3,255,959	4,661,637	0.394875	0.000000 73.00
OUTPATIENT SERVICE COST CENTERS						
91.00	EMERGENCY	257,381	8,763,718	9,021,099	0.347163	0.000000 91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	477,316	477,316	1.127762	0.000000 92.00
200.00	Subtotal (see instructions)	8,683,179	45,352,456	54,035,635		200.00
201.00	Less Observation Beds					201.00
202.00	Total (see instructions)	8,683,179	45,352,456	54,035,635		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151309

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

Worksheet C
Part I
Date/Time Prepared:
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Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.000000			50.00
53.00	ANESTHESIOLOGY	0.000000			53.00
54.00	RADIOLOGY - DIAGNOSTIC	0.000000			54.00
60.00	LABORATORY	0.000000			60.00
65.00	RESPIRATORY THERAPY	0.000000			65.00
66.00	PHYSICAL THERAPY	0.000000			66.00
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
OUTPATIENT SERVICE COST CENTERS					
91.00	EMERGENCY	0.000000			91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

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

Provider CCN: 151309

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

Worksheet C
Part II
Date/Time Prepared:
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Cost Center Description	Title XIX			Hospital	Cost	
	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	1,643,583	144,280	1,499,303	0	0 50.00
53.00	ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00	RADIOLOGY - DIAGNOSTIC	2,010,181	166,852	1,843,329	0	0 54.00
60.00	LABORATORY	2,027,546	154,229	1,873,317	0	0 60.00
65.00	RESPIRATORY THERAPY	500,910	58,213	442,697	0	0 65.00
66.00	PHYSICAL THERAPY	1,145,581	152,897	992,684	0	0 66.00
68.00	SPEECH PATHOLOGY	5,711	162	5,549	0	0 68.00
69.00	ELECTROCARDIOLOGY	241,895	15,633	226,262	0	0 69.00
70.00	ELECTROENCEPHALOGRAPHY	5,935	368	5,567	0	0 70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,209,429	83,195	1,126,234	0	0 71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	282,585	10,366	272,219	0	0 72.00
73.00	DRUGS CHARGED TO PATIENTS	1,840,762	95,486	1,745,276	0	0 73.00
OUTPATIENT SERVICE COST CENTERS						
91.00	EMERGENCY	3,131,790	270,273	2,861,517	0	0 91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	538,299	0	538,299	0	0 92.00
200.00	Subtotal (sum of lines 50 thru 199)	14,584,207	1,151,954	13,432,253	0	0 200.00
201.00	Less Observation Beds	538,299	0	538,299	0	0 201.00
202.00	Total (line 200 minus line 201)	14,045,908	613,655	12,893,954	0	0 202.00

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

Provider CCN: 151309

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

Worksheet C
Part II
Date/Time Prepared:
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Cost Center Description		Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	Hospital	Cost
		6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	1,643,583	5,788,192	0.283954		50.00
53.00	ANESTHESIOLOGY	0	0	0.000000		53.00
54.00	RADIOLOGY - DIAGNOSTIC	2,010,181	14,219,487	0.141368		54.00
60.00	LABORATORY	2,027,546	9,175,401	0.220976		60.00
65.00	RESPIRATORY THERAPY	500,910	650,177	0.770421		65.00
66.00	PHYSICAL THERAPY	1,145,581	2,524,578	0.453771		66.00
68.00	SPEECH PATHOLOGY	5,711	230	24.830435		68.00
69.00	ELECTROCARDIOLOGY	241,895	1,842,014	0.131321		69.00
70.00	ELECTROENCEPHALOGRAPHY	5,935	41,946	0.141491		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,209,429	2,749,711	0.439839		71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	282,585	621,372	0.454776		72.00
73.00	DRUGS CHARGED TO PATIENTS	1,840,762	4,661,637	0.394875		73.00
OUTPATIENT SERVICE COST CENTERS						
91.00	EMERGENCY	3,131,790	9,021,099	0.347163		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	538,299	477,316	1.127762		92.00
200.00	Subtotal (sum of lines 50 thru 199)	14,584,207	0			200.00
201.00	Less Observation Beds	538,299	0			201.00
202.00	Total (line 200 minus line 201)	14,045,908	105,808,795			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 151309		Period: From 07/01/2010 To 06/30/2011		Worksheet D Part II Date/Time Prepared: 1/31/2012 8:54 am	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Hospital Inpatient Program Charges	Capital Costs (column 3 x column 4)	Cost
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	144,280	5,788,192	0.024927	333,941	8,324	50.00
53.00	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	RADIOLOGY - DIAGNOSTIC	166,852	14,219,487	0.011734	626,361	7,350	54.00
60.00	LABORATORY	154,229	9,175,401	0.016809	506,796	8,519	60.00
65.00	RESPIRATORY THERAPY	58,213	650,177	0.089534	240,560	21,538	65.00
66.00	PHYSICAL THERAPY	152,897	2,524,578	0.060563	113,949	6,901	66.00
68.00	SPEECH PATHOLOGY	162	230	0.704348	230	162	68.00
69.00	ELECTROCARDIOLOGY	15,633	1,842,014	0.008487	51,106	434	69.00
70.00	ELECTROENCEPHALOGRAPHY	368	41,946	0.008773	5,405	47	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	83,195	2,749,711	0.030256	429,349	12,990	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	10,366	621,372	0.016682	292,958	4,887	72.00
73.00	DRUGS CHARGED TO PATIENTS	95,486	4,661,637	0.020483	728,328	14,918	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	EMERGENCY	270,273	9,021,099	0.029960	1,068	32	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	477,316	0.000000	0	0	92.00
200.00	Total (lines 50-199)	1,151,954	51,773,160		3,330,051	86,102	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151309	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part IV Date/Time Prepared: 1/31/2012 8:54 am
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Cost Center Description	Title XVIII				Hospital	Cost	Total Cost (sum of col 1 through col. 4)	
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost				
	1.00	2.00	3.00	4.00		5.00		
ANCILLARY SERVICE COST CENTERS								
50.00 OPERATING ROOM	0	0	0	0	0	0	0	50.00
53.00 ANESTHESIOLOGY	0	0	0	0	0	0	0	53.00
54.00 RADIOLOGY - DIAGNOSTIC	0	0	0	0	0	0	0	54.00
60.00 LABORATORY	0	0	0	0	0	0	0	60.00
65.00 RESPIRATORY THERAPY	0	0	0	0	0	0	0	65.00
66.00 PHYSICAL THERAPY	0	0	0	0	0	0	0	66.00
68.00 SPEECH PATHOLOGY	0	0	0	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	0	0	0	0	0	0	0	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	0	71.00
72.00 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
91.00 EMERGENCY	0	0	0	0	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	0	92.00
200.00 Total (lines 50-199)	0	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151309

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

Worksheet D
Part IV
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Cost Center Description		Title XVIII			Hospital		
		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	0	5,788,192	0.000000	0.000000	333,941	50.00
53.00	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	RADIOLOGY - DIAGNOSTIC	0	14,219,487	0.000000	0.000000	626,361	54.00
60.00	LABORATORY	0	9,175,401	0.000000	0.000000	506,796	60.00
65.00	RESPIRATORY THERAPY	0	650,177	0.000000	0.000000	240,560	65.00
66.00	PHYSICAL THERAPY	0	2,524,578	0.000000	0.000000	113,949	66.00
68.00	SPEECH PATHOLOGY	0	230	0.000000	0.000000	230	68.00
69.00	ELECTROCARDIOLOGY	0	1,842,014	0.000000	0.000000	51,106	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	41,946	0.000000	0.000000	5,405	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,749,711	0.000000	0.000000	429,349	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	621,372	0.000000	0.000000	292,958	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	4,661,637	0.000000	0.000000	728,328	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	EMERGENCY	0	9,021,099	0.000000	0.000000	1,068	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	477,316	0.000000	0.000000	0	92.00
200.00	Total (lines 50-199)	0	51,773,160			3,330,051	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151309

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

Worksheet D
Part IV
Date/Time Prepared:
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Cost Center Description	Title XVIII			Hospital		Cost
	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
	11.00	12.00	13.00	21.00	22.00	
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	0	0	0	0	50.00
53.00 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 RADIOLOGY - DIAGNOSTIC	0	0	0	0	0	54.00
60.00 LABORATORY	0	0	0	0	0	60.00
65.00 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 PHYSICAL THERAPY	0	0	0	0	0	66.00
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
OUTPATIENT SERVICE COST CENTERS						
91.00 EMERGENCY	0	0	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00 Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151309	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part IV Date/Time Prepared: 1/31/2012 8:54 am
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Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	Title XVIII	Hospital	Cost
ANCILLARY SERVICE COST CENTERS		23.00	24.00			
50.00	OPERATING ROOM	0	0			50.00
53.00	ANESTHESIOLOGY	0	0			53.00
54.00	RADIOLOGY - DIAGNOSTIC	0	0			54.00
60.00	LABORATORY	0	0			60.00
65.00	RESPIRATORY THERAPY	0	0			65.00
66.00	PHYSICAL THERAPY	0	0			66.00
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
OUTPATIENT SERVICE COST CENTERS						
91.00	EMERGENCY	0	0			91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0			92.00
200.00	Total (lines 50-199)	0	0			200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 151309 Period: From 07/01/2010 To 06/30/2011 Worksheet D Part V Date/Time Prepared: 1/31/2012 8:54 am

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Cost
		PPS Reimbursed Services (see instructions)	Cost Reimbursed Subject To Ded. & Coins. (see instructions)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)	
		1.00	2.00	3.00	
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	0.283954	0	1,912,460	0	50.00
53.00 ANESTHESIOLOGY	0.000000	0	0	0	53.00
54.00 RADIOLOGY - DIAGNOSTIC	0.141368	0	4,267,744	0	54.00
60.00 LABORATORY	0.220976	0	2,923,975	0	60.00
65.00 RESPIRATORY THERAPY	0.770421	0	103,830	0	65.00
66.00 PHYSICAL THERAPY	0.453771	0	710,183	0	66.00
68.00 SPEECH PATHOLOGY	24.830435	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	0.131321	0	206,846	0	69.00
70.00 ELECTROENCEPHALOGRAPHY	0.141491	0	11,423	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.439839	0	752,706	0	71.00
72.00 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.454776	0	190,345	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0.394875	0	2,138,517	2,707	73.00
OUTPATIENT SERVICE COST CENTERS					
91.00 EMERGENCY	0.347163	0	2,168,781	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	1.121532	0	274,481	0	92.00
200.00 Subtotal (see instructions)		0	15,661,291	2,707	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	15,661,291	2,707	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151309	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part V Date/Time Prepared: 1/31/2012 8:54 am
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Cost Center Description	Title XVIII			Hospital	Cost
	Costs				
	PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)		
	5.00	6.00	7.00		
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	0	543,051	0		50.00
53.00 ANESTHESIOLOGY	0	0	0		53.00
54.00 RADIOLOGY - DIAGNOSTIC	0	603,322	0		54.00
60.00 LABORATORY	0	646,128	0		60.00
65.00 RESPIRATORY THERAPY	0	79,993	0		65.00
66.00 PHYSICAL THERAPY	0	322,260	0		66.00
68.00 SPEECH PATHOLOGY	0	0	0		68.00
69.00 ELECTROCARDIOLOGY	0	27,163	0		69.00
70.00 ELECTROENCEPHALOGRAPHY	0	1,616	0		70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	331,069	0		71.00
72.00 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	86,564	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	0	844,447	1,069		73.00
OUTPATIENT SERVICE COST CENTERS					
91.00 EMERGENCY	0	752,921	0		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	307,839	0		92.00
200.00 Subtotal (see instructions)	0	4,546,373	1,069		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00 Net Charges (line 200 +/- line 201)	0	4,546,373	1,069		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 151309	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part II Date/Time Prepared: 1/31/2012 8:54 am
	Component CCN:		

Cost Center Description		Capital Related Cost (from wkst. B, Part II, col. 26)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	144,280	5,788,192	0.024927	0	0	50.00
53.00	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	RADIOLOGY - DIAGNOSTIC	166,852	14,219,487	0.011734	0	0	54.00
60.00	LABORATORY	154,229	9,175,401	0.016809	0	0	60.00
65.00	RESPIRATORY THERAPY	58,213	650,177	0.089534	0	0	65.00
66.00	PHYSICAL THERAPY	152,897	2,524,578	0.060563	0	0	66.00
68.00	SPEECH PATHOLOGY	162	230	0.704348	0	0	68.00
69.00	ELECTROCARDIOLOGY	15,633	1,842,014	0.008487	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	368	41,946	0.008773	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	83,195	2,749,711	0.030256	0	0	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	10,366	621,372	0.016682	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	95,486	4,661,637	0.020483	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	EMERGENCY	270,273	9,021,099	0.029960	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	477,316	0.000000	0	0	92.00
200.00	Total (lines 50-199)	1,151,954	51,773,160		0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151309	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part IV Date/Time Prepared: 1/31/2012 8:54 am
	Component CCN:	Title XVIII	Subprovider - IPF

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	
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	0	0	0	0	50.00
53.00 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 RADIOLOGY - DIAGNOSTIC	0	0	0	0	0	54.00
60.00 LABORATORY	0	0	0	0	0	60.00
65.00 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 PHYSICAL THERAPY	0	0	0	0	0	66.00
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
OUTPATIENT SERVICE COST CENTERS						
91.00 EMERGENCY	0	0	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00 Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151309	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part IV Date/Time Prepared: 1/31/2012 8:54 am
	Component CCN:		

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	0	5,788,192	0.000000	0.000000	0	50.00
53.00	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	RADIOLOGY - DIAGNOSTIC	0	14,219,487	0.000000	0.000000	0	54.00
60.00	LABORATORY	0	9,175,401	0.000000	0.000000	0	60.00
65.00	RESPIRATORY THERAPY	0	650,177	0.000000	0.000000	0	65.00
66.00	PHYSICAL THERAPY	0	2,524,578	0.000000	0.000000	0	66.00
68.00	SPEECH PATHOLOGY	0	230	0.000000	0.000000	0	68.00
69.00	ELECTROCARDIOLOGY	0	1,842,014	0.000000	0.000000	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	41,946	0.000000	0.000000	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,749,711	0.000000	0.000000	0	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	621,372	0.000000	0.000000	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	4,661,637	0.000000	0.000000	0	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	EMERGENCY	0	9,021,099	0.000000	0.000000	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	477,316	0.000000	0.000000	0	92.00
200.00	Total (lines 50-199)	0	51,773,160			0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151309 Component CCN:	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part IV Date/Time Prepared: 1/31/2012 8:54 am
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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	
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	0	0	0	0	0	50.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY - DIAGNOSTIC	0	0	0	0	0	54.00
60.00	LABORATORY	0	0	0	0	0	60.00
65.00	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	0	0	0	66.00
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
OUTPATIENT SERVICE COST CENTERS							
91.00	EMERGENCY	0	0	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00	Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151309 Component CCN:	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part IV Date/Time Prepared: 1/31/2012 8:54 am
	Title XVIII	Subprovider - IPF	

Cost Center Description	PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	
	23.00	24.00	
ANCILLARY SERVICE COST CENTERS			
50.00 OPERATING ROOM	0	0	50.00
53.00 ANESTHESIOLOGY	0	0	53.00
54.00 RADIOLOGY - DIAGNOSTIC	0	0	54.00
60.00 LABORATORY	0	0	60.00
65.00 RESPIRATORY THERAPY	0	0	65.00
66.00 PHYSICAL THERAPY	0	0	66.00
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
OUTPATIENT SERVICE COST CENTERS			
91.00 EMERGENCY	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00 Total (lines 50-199)	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151309	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part V Date/Time Prepared: 1/31/2012 8:54 am
	Component CCN:152309		

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)		
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0.283954	0	0	0	50.00
53.00	ANESTHESIOLOGY	0.000000	0	0	0	53.00
54.00	RADIOLOGY - DIAGNOSTIC	0.141368	0	0	0	54.00
60.00	LABORATORY	0.220976	0	0	0	60.00
65.00	RESPIRATORY THERAPY	0.770421	0	0	0	65.00
66.00	PHYSICAL THERAPY	0.453771	0	0	0	66.00
68.00	SPEECH PATHOLOGY	24.830435	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0.131321	0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0.141491	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.439839	0	0	0	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.454776	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.394875	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
91.00	EMERGENCY	0.347163	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.121532	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: 151309	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part V Date/Time Prepared: 1/31/2012 8:54 am
	Component CCN: 152309		

Cost Center Description	Costs			Swing Beds - SNF	Cost
	PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)		
	5.00	6.00	7.00		
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	0	0	0		50.00
53.00 ANESTHESIOLOGY	0	0	0		53.00
54.00 RADIOLOGY - DIAGNOSTIC	0	0	0		54.00
60.00 LABORATORY	0	0	0		60.00
65.00 RESPIRATORY THERAPY	0	0	0		65.00
66.00 PHYSICAL THERAPY	0	0	0		66.00
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
OUTPATIENT SERVICE COST CENTERS					
91.00 EMERGENCY	0	0	0		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00 Subtotal (see instructions)	0	0	0		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0		201.00
202.00 Net Charges (line 200 +/- line 201)	0	0	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 151309		Period: From 07/01/2010 To 06/30/2011		Worksheet D Part I Date/Time Prepared: 1/31/2012 8:54 am	
Cost Center Description		Capital Related Cost (from wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Hospital Total Patient Days	Cost Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	339,073	80,905	258,168	2,556	101.00	30.00
200.00	Total (lines 30-199)	339,073		258,168	2,556		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS	Provider CCN: 151309	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part I Date/Time Prepared: 1/31/2012 8:54 am
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Cost Center Description	Title XIX		Hospital	Cost
	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)		
	6.00	7.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00 ADULTS & PEDIATRICS	222	22,422		30.00
200.00 Total (lines 30-199)	222	22,422		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 151309

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

Worksheet D
Part II
Date/Time Prepared:
1/31/2012 8:54 am

Cost Center Description	Title XIX			Hospital		Capital Costs (column 3 x column 4)	
	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Cost		
	1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	144,280	5,788,192	0.024927	67,615	1,685	50.00
53.00	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	RADIOLOGY - DIAGNOSTIC	166,852	14,219,487	0.011734	71,587	840	54.00
60.00	LABORATORY	154,229	9,175,401	0.016809	62,347	1,048	60.00
65.00	RESPIRATORY THERAPY	58,213	650,177	0.089534	109,914	9,841	65.00
66.00	PHYSICAL THERAPY	152,897	2,524,578	0.060563	2,316	140	66.00
68.00	SPEECH PATHOLOGY	162	230	0.704348	0	0	68.00
69.00	ELECTROCARDIOLOGY	15,633	1,842,014	0.008487	18,050	153	69.00
70.00	ELECTROENCEPHALOGRAPHY	368	41,946	0.008773	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	83,195	2,749,711	0.030256	76,130	2,303	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	10,366	621,372	0.016682	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	95,486	4,661,637	0.020483	150,567	3,084	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	EMERGENCY	270,273	9,021,099	0.029960	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	477,316	0.000000	0	0	92.00
200.00	Total (lines 50-199)	1,151,954	51,773,160		558,526	19,094	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 151309		Period: From 07/01/2010 To 06/30/2011		Worksheet D Part III Date/Time Prepared: 1/31/2012 8:54 am	
		Title XIX		Hospital		Cost	
Cost Center Description		Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	0	0	0	0	0 30.00	
200.00	Total (lines 30-199)	0	0	0	0	0 200.00	

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 151309		Period: From 07/01/2010 To 06/30/2011		Worksheet D Part III Date/Time Prepared: 1/31/2012 8:54 am	
Cost Center Description		Title XIX		Hospital		Cost	
		Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. Nursing School	
		6.00	7.00	8.00	9.00	11.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	2,556	0.00	222	0	0	30.00
200.00	Total (lines 30-199)	2,556		222	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151309	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part III Date/Time Prepared: 1/31/2012 8:54 am
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Cost Center Description	Title XIX		Hospital	Cost
	PSA Adj. Allied Health Cost	PSA Adj. All Other Medical Education Cost		
	12.00	13.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00 ADULTS & PEDIATRICS	0	0		30.00
200.00 Total (lines 30-199)	0	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151309

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

Worksheet D
Part IV
Date/Time Prepared:
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Cost Center Description	Title XIX			Hospital	Cost	
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	0	0	0	0	50.00
53.00 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 RADIOLOGY - DIAGNOSTIC	0	0	0	0	0	54.00
60.00 LABORATORY	0	0	0	0	0	60.00
65.00 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 PHYSICAL THERAPY	0	0	0	0	0	66.00
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
OUTPATIENT SERVICE COST CENTERS						
91.00 EMERGENCY	0	0	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00 Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151309

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

Worksheet D
Part IV
Date/Time Prepared:
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Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Title XIX		Hospital		Cost
		Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
	6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	5,788,192	0.000000	0.000000	67,615	50.00
53.00 ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00 RADIOLOGY - DIAGNOSTIC	0	14,219,487	0.000000	0.000000	71,587	54.00
60.00 LABORATORY	0	9,175,401	0.000000	0.000000	62,347	60.00
65.00 RESPIRATORY THERAPY	0	650,177	0.000000	0.000000	109,914	65.00
66.00 PHYSICAL THERAPY	0	2,524,578	0.000000	0.000000	2,316	66.00
68.00 SPEECH PATHOLOGY	0	230	0.000000	0.000000	0	68.00
69.00 ELECTROCARDIOLOGY	0	1,842,014	0.000000	0.000000	18,050	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	41,946	0.000000	0.000000	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,749,711	0.000000	0.000000	76,130	71.00
72.00 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	621,372	0.000000	0.000000	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	4,661,637	0.000000	0.000000	150,567	73.00
OUTPATIENT SERVICE COST CENTERS						
91.00 EMERGENCY	0	9,021,099	0.000000	0.000000	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	477,316	0.000000	0.000000	0	92.00
200.00 Total (lines 50-199)	0	51,773,160			558,526	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151309

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

Worksheet D
Part IV
Date/Time Prepared:
1/31/2012 8:54 am

Cost Center Description	Title XIX			Hospital		PSA Adj. Cost	PSA Adj. Nursing School	
	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				
	11.00	12.00	13.00	21.00	22.00			
ANCILLARY SERVICE COST CENTERS								
50.00	OPERATING ROOM	0	0	0	0	0	0	50.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00	RADIOLOGY - DIAGNOSTIC	0	0	0	0	0	0	54.00
60.00	LABORATORY	0	0	0	0	0	0	60.00
65.00	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
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
OUTPATIENT SERVICE COST CENTERS								
91.00	EMERGENCY	0	0	0	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00
200.00	Total (lines 50-199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151309

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

Worksheet D
Part IV
Date/Time Prepared:
1/31/2012 8:54 am

Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	
		23.00	24.00	
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0	0	50.00
53.00	ANESTHESIOLOGY	0	0	53.00
54.00	RADIOLOGY - DIAGNOSTIC	0	0	54.00
60.00	LABORATORY	0	0	60.00
65.00	RESPIRATORY THERAPY	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	66.00
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
OUTPATIENT SERVICE COST CENTERS				
91.00	EMERGENCY	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00	Total (lines 50-199)	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151309	Period: From 07/01/2010 To 06/30/2011	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 1/31/2012 8:54 am
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,484	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,556	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)		2,556	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		409	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)		392	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)		127	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		1,418	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)		409	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)		392	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		146.75	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		146.75	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,371,414	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)		18,637	25.00
26.00	Total swing-bed cost (see instructions)		818,628	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,552,786	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		2,277,268	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		2,277,268	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		1.120986	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)		890.95	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)		2,552,786	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		998.74	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,416,213	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)		1,416,213	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151309

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

Worksheet D-1

Date/Time Prepared:
1/31/2012 8:54 am

Cost Center Description	Title XVIII			Hospital	Cost	
	Total	Total	Average Per	Program Days	Program Cost	
	Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)		(col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT						43.00
44.00 CORONARY CARE UNIT						44.00
45.00 BURN INTENSIVE CARE UNIT						45.00
46.00 SURGICAL INTENSIVE CARE UNIT						46.00
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description					1.00	
48.00 Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					1,155,631	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,571,844	49.00
PASS THROUGH COST ADJUSTMENTS						
50.00 Pass through costs applicable to Program inpatient routine services (from wkst. D, sum of Parts I and III)					0	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from wkst. D, sum of Parts II and IV)					0	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00 Program discharges					0	54.00
55.00 Target amount per discharge					0.00	55.00
56.00 Target amount (line 54 x line 55)					0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00 Bonus payment (see instructions)					0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00 Relief payment (see instructions)					0	62.00
63.00 Allowable inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					408,485	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					391,506	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					799,991	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY						
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)						70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00 Program routine service cost (line 9 x line 71)						72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from worksheet B, Part II, column 26, line 45)						75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00 Program capital-related costs (line 9 x line 76)						77.00
78.00 Inpatient routine service cost (line 74 minus line 77)						78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00 Inpatient routine service cost per diem limitation						81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00 Reasonable inpatient routine service costs (see instructions)						83.00
84.00 Program inpatient ancillary services (see instructions)						84.00
85.00 Utilization review - physician compensation (see instructions)						85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00 Total observation bed days (see instructions)					536	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					998.74	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					535,325	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151309

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

Worksheet D-1

Date/Time Prepared:
1/31/2012 8:54 am

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

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 151309	Period: From 07/01/2010 To 06/30/2011	Worksheet D-1
	Component CCN:		Date/Time Prepared: 1/31/2012 8:54 am
	Title XVIII	Subprovider - IPF	

Cost Center Description		1.00	
PART I - ALL PROVIDER COMPONENTS			
INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	0	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	0	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)	0	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)	0	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
SWING BED ADJUSTMENT			
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	0	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)	0	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28.00	General inpatient routine service charges (excluding swing-bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	0	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY			
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS			
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	0.00	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	0	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)	0	41.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 151309	Period: From 07/01/2010 To 06/30/2011	Worksheet D-1
	Component CCN:		Date/Time Prepared: 1/31/2012 8:54 am

	Title XVIII	Subprovider - IPF	
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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)	
42.00 NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00	42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT						43.00
44.00 CORONARY CARE UNIT						44.00
45.00 BURN INTENSIVE CARE UNIT						45.00
46.00 SURGICAL INTENSIVE CARE UNIT						46.00
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						
					1.00	
48.00 Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					0	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					0	49.00
PASS THROUGH COST ADJUSTMENTS						
50.00 Pass through costs applicable to Program inpatient routine services (from wkst. D, sum of Parts I and III)					0	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from wkst. D, sum of Parts II and IV)					0	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00 Program discharges					0	54.00
55.00 Target amount per discharge					0.00	55.00
56.00 Target amount (line 54 x line 55)					0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00 Bonus payment (see instructions)					0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00 Relief payment (see instructions)					0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY						
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)						70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00 Program routine service cost (line 9 x line 71)						72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00 Program capital-related costs (line 9 x line 76)						77.00
78.00 Inpatient routine service cost (line 74 minus line 77)						78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00 Inpatient routine service cost per diem limitation						81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00 Reasonable inpatient routine service costs (see instructions)						83.00
84.00 Program inpatient ancillary services (see instructions)						84.00
85.00 Utilization review - physician compensation (see instructions)						85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00 Total observation bed days (see instructions)					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: 151309	Period: From 07/01/2010 To 06/30/2011	Worksheet D-1
	Component CCN:		Date/Time Prepared: 1/31/2012 8:54 am

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

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151309	Period: From 07/01/2010 To 06/30/2011	Worksheet D-1 Date/Time Prepared: 1/31/2012 8:54 am
Cost Center Description		Title XIX	Hospital	Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS:				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			3,484 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			2,556 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)			2,556 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)			801 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)			127 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			222 9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			0 10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0 14.00
15.00	Total nursery days (title V or XIX only)			0 15.00
16.00	Nursery days (title V or XIX only)			0 16.00
SWING BED ADJUSTMENT:				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			0.00 17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			0.00 18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			0.00 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			0.00 20.00
21.00	Total general inpatient routine service cost (see instructions)			3,371,414 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)			804,436 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			2,566,978 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT:				
28.00	General inpatient routine service charges (excluding swing-bed charges)			2,277,268 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			2,277,268 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			1.127218 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)			890.95 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)			2,566,978 37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			1,004.29 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			222,952 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)			222,952 41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151309

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

Worksheet D-1

Date/Time Prepared:
1/31/2012 8:54 am

Cost Center Description		Title XIX			Hospital	Cost	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
42.00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					224,138	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					447,090	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST							
87.00	Total observation bed days (see instructions)					536	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,004.29	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					538,299	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 151309	Period: From 07/01/2010 To 06/30/2011	Worksheet D-1 Date/Time Prepared: 1/31/2012 8:54 am
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Cost Center Description	Cost	Title XIX		Hospital		Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)
		Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Cost	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	0	0	0.000000	0	0	90.00
91.00 Nursing School cost	0	0	0.000000	0	0	91.00
92.00 Allied health cost	0	0	0.000000	0	0	92.00
93.00 All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151309	Period: From 07/01/2010 To 06/30/2011	Worksheet D-3
Cost Center Description		Title XVIII	Hospital	Cost
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS		1,318,564	30.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0.283954	333,941	94,824 50.00
53.00	ANESTHESIOLOGY	0.000000	0	0 53.00
54.00	RADIOLOGY - DIAGNOSTIC	0.141368	626,361	88,547 54.00
60.00	LABORATORY	0.220976	506,796	111,990 60.00
65.00	RESPIRATORY THERAPY	0.770421	240,560	185,332 65.00
66.00	PHYSICAL THERAPY	0.453771	113,949	51,707 66.00
68.00	SPEECH PATHOLOGY	24.830435	230	5,711 68.00
69.00	ELECTROCARDIOLOGY	0.131321	51,106	6,711 69.00
70.00	ELECTROENCEPHALOGRAPHY	0.141491	5,405	765 70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.439839	429,349	188,844 71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.454776	292,958	133,230 72.00
73.00	DRUGS CHARGED TO PATIENTS	0.394875	728,328	287,599 73.00
OUTPATIENT SERVICE COST CENTERS				
91.00	EMERGENCY	0.347163	1,068	371 91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.121532	0	0 92.00
200.00	Total (sum of lines 50-94 and 96-98)		3,330,051	1,155,631 200.00
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)		3,330,051	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 151309	Period: From 07/01/2010 To 06/30/2011	Worksheet D-3
	Component CCN:		Date/Time Prepared: 1/31/2012 8:54 am
	Title XVIII	Subprovider - IPF	

Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS		0		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.000000	0	0	50.00
53.00	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	RADIOLOGY - DIAGNOSTIC	0.000000	0	0	54.00
60.00	LABORATORY	0.000000	0	0	60.00
65.00	RESPIRATORY THERAPY	0.000000	0	0	65.00
66.00	PHYSICAL THERAPY	0.000000	0	0	66.00
68.00	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	ELECTROCARDIOLOGY	0.000000	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.000000	0	0	73.00
OUTPATIENT SERVICE COST CENTERS					
91.00	EMERGENCY	0.000000	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		0	0	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)		0	0	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151309	Period: From 07/01/2010 To 06/30/2011	Worksheet D-3
		Component CCN: 152309		Date/Time Prepared: 1/31/2012 8:54 am
Cost Center Description		Title XVIII	Swing Beds - SNF	Cost
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS		286,582	30.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0.283954	0	50.00
53.00	ANESTHESIOLOGY	0.000000	0	53.00
54.00	RADIOLOGY - DIAGNOSTIC	0.141368	40,865	54.00
60.00	LABORATORY	0.220976	72,819	60.00
65.00	RESPIRATORY THERAPY	0.770421	71,295	65.00
66.00	PHYSICAL THERAPY	0.453771	337,571	66.00
68.00	SPEECH PATHOLOGY	24.830435	0	68.00
69.00	ELECTROCARDIOLOGY	0.131321	4,356	69.00
70.00	ELECTROENCEPHALOGRAPHY	0.141491	1,302	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.439839	59,848	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.454776	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.394875	215,866	73.00
OUTPATIENT SERVICE COST CENTERS				
91.00	EMERGENCY	0.347163	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.121532	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		803,922	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)		803,922	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 151309	Period: From 07/01/2010 To 06/30/2011	Worksheet D-3 Date/Time Prepared: 1/31/2012 8:54 am
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Cost Center Description	Title XIX		Hospital		Cost
	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)		
	1.00	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 ADULTS & PEDIATRICS		223,465			30.00
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	0.283954	67,615	19,200		50.00
53.00 ANESTHESIOLOGY	0.000000	0	0		53.00
54.00 RADIOLOGY - DIAGNOSTIC	0.141368	71,587	10,120		54.00
60.00 LABORATORY	0.220976	62,347	13,777		60.00
65.00 RESPIRATORY THERAPY	0.770421	109,914	84,680		65.00
66.00 PHYSICAL THERAPY	0.453771	2,316	1,051		66.00
68.00 SPEECH PATHOLOGY	24.830435	0	0		68.00
69.00 ELECTROCARDIOLOGY	0.131321	18,050	2,370		69.00
70.00 ELECTROENCEPHALOGRAPHY	0.141491	0	0		70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.439839	76,130	33,485		71.00
72.00 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.454776	0	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	0.394875	150,567	59,455		73.00
OUTPATIENT SERVICE COST CENTERS					
91.00 EMERGENCY	0.347163	0	0		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	1.127762	0	0		92.00
200.00 Total (sum of lines 50-94 and 96-98)		558,526	224,138		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)		558,526			202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151309	Period: From 07/01/2010 To 06/30/2011	Worksheet E Part B Date/Time Prepared: 1/31/2012 8:54 am
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		4,547,442	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	PPS payments		0	3.00
4.00	Outlier payment (see instructions)		0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from worksheet D, Part IV, column 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		4,547,442	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from worksheet D-4, Part III, line 69, col. 4)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)		4,592,916	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		0	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		49,316	25.00
26.00	Deductibles and coinsurance relating to amount on line 24 (for CAH, see instructions)		2,541,111	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)		2,002,489	27.00
28.00	Direct graduate medical education payments (from worksheet E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from worksheet E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		2,002,489	30.00
31.00	Primary payer payments		314	31.00
32.00	Subtotal (line 30 minus line 31)		2,002,175	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from worksheet I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		459,464	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		459,464	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		389,769	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)		2,461,639	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)		2,461,639	40.00
41.00	Interim payments		2,615,299	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)		-153,660	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151309	Period: From 07/01/2010 To 06/30/2011	Worksheet E Part B Date/Time Prepared: 1/31/2012 8:54 am
	Title XVIII	Hospital	Cost
			Overrides
			1.00
WORKSHEET OVERRIDE VALUES			
112.00	Override of Ancillary service charges (line 12)		0 112.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151309	Period: From 07/01/2010 To 06/30/2011	Worksheet E Part B Date/Time Prepared: 1/31/2012 8:54 am
		Component CCN:	Title XVIII	Subprovider - IPF
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
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
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from worksheet D-4, Part III, line 69, col. 4)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR 413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)		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
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		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
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from worksheet I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		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
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151309	Period: From 07/01/2010	Worksheet E
	Component CCN:	To 06/30/2011	Part B
	Title XVIII	Subprovider - IPF	Date/Time Prepared: 1/31/2012 8:54 am
			Overrides
			1.00
WORKSHEET OVERRIDE VALUES			
112.00	Override of Ancillary service charges (line 12)		0 112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 151309	Period: From 07/01/2010 To 06/30/2011	Worksheet E-1 Part I Date/Time Prepared: 1/31/2012 8:54 am	
		Title XVIII	Hospital	Cost	
		Inpatient Part A		Part B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount
		1.00	2.00	3.00	4.00
1.00	Total interim payments paid to provider		2,001,510		2,748,095
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)				
Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	06/07/2011	34,869	06/07/2011	75,045
3.02			0		0
3.03			0		0
3.04			0		0
3.05			0		0
Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM	06/07/2011	10,839	06/07/2011	207,841
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)		24,030		-132,796
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to wkst. E or wkst. E-3, line and column as appropriate)		2,025,540		2,615,299
TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				
Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0
5.02			0		0
5.03			0		0
Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0
5.51			0		0
5.52			0		0
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				
6.01	SETTLEMENT TO PROVIDER		258,259		0
6.02	SETTLEMENT TO PROGRAM		0		153,660
7.00	Total Medicare program liability (see instructions)		2,283,799		2,461,639
				Contractor Number	Date (Mo/Day/Yr)
			0	1.00	2.00
8.00	Name of Contractor				

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 151309		Period: From 07/01/2010 To 06/30/2011		Worksheet E-1 Part I Date/Time Prepared: 1/31/2012 8:54 am	
		Component CCN:		Title XVIII		Subprovider - IPF	
		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		0		0	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to wkst. E or wkst. E-3, line and column as appropriate)		0		0	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00	
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00	
6.01	SETTLEMENT TO PROVIDER		0		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		0		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: 151309	Period: From 07/01/2010 To 06/30/2011	Worksheet E-1 Part I Date/Time Prepared: 1/31/2012 8:54 am
	Component CCN: 152309		

		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				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		1,038,710		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM	06/07/2011	2,976		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)		-2,976		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)		1,035,734		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		117,149		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,152,883		0	7.00
				Contractor Number	Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 151309	Period: From 07/01/2010 To 06/30/2011	Worksheet E-2
	Component CCN: 152309		Date/Time Prepared: 1/31/2012 8:54 am

		Swing Beds - SNF		Cost
		Part A	Part B	
		1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)	807,991	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)	345,717	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	801	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)	1,153,708	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,153,708	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)	1,153,708	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	825	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)	1,152,883	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)	1,152,883	0	19.00
20.00	Interim payments	1,035,734	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)	117,149	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: 151309	Period: From 07/01/2010 To 06/30/2011	Worksheet E-3 Part V Date/Time Prepared: 1/31/2012 8:54 am
	Title XVIII	Hospital	Cost

			1.00	
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)				
1.00	Inpatient services		2,571,844	1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction)		0	2.00
3.00	Organ acquisition		0	3.00
4.00	Subtotal (sum of lines 1 thru 3)		2,571,844	4.00
5.00	Primary payer payments		9,391	5.00
6.00	Total cost (line 4 less line 5) . For CAH (see instructions)		2,588,171	6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
7.00	Routine service charges		0	7.00
8.00	Ancillary service charges		0	8.00
9.00	Organ acquisition charges, net of revenue		0	9.00
10.00	Total reasonable charges		0	10.00
Customary charges				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)		0.000000	13.00
14.00	Total customary charges (see instructions)		0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)		0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)		0	16.00
17.00	Cost of teaching physicians (from worksheet D-5, Part II, column 3, line 20) (see instructions)		0	17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from worksheet E-4, line 49)		0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)		2,588,171	19.00
20.00	Deductibles (exclude professional component)		346,432	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20)		2,241,739	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		2,241,739	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		42,060	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		42,060	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		30,015	27.00
28.00	Subtotal (sum of lines 24 and 25 or 26)		2,283,799	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	29.00
29.99	Recovery of Accelerated Depreciation		0	29.99
30.00	Subtotal (line 28, plus or minus lines 29)		2,283,799	30.00
31.00	Interim payments		2,025,540	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)		258,259	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: 151309	Period: From 07/01/2010 To 06/30/2011	Worksheet E-3 Part II Date/Time Prepared: 1/31/2012 8:54 am
		Component CCN:	Title XVIII	Subprovider - IPF

		1.00	
PART II - MEDICARE PART A SERVICES - IPF PPS			
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	0	1.00
2.00	Net IPF PPS Outlier Payments	0	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)	0.000000	9.00
10.00	Medical Education Adjustment Factor {((1 + (line 8/line 9)) 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)	0	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)	0	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	0	18.00
19.00	Deductibles	0	19.00
20.00	Subtotal (line 18 minus line 19)	0	20.00
21.00	Coinsurance	0	21.00
22.00	Subtotal (line 20 minus line 21)	0	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)	0	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)	0	31.00
32.00	Interim payments	0	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
TO BE COMPLETED BY CONTRACTOR			
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: 151309	Period: From 07/01/2010 To 06/30/2011	Worksheet E-3 Part VII Date/Time Prepared: 1/31/2012 8:54 am
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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	447,090	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)	447,090	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)	447,090	7.00
COMPUTATION OF LESSER OF COST OR CHARGES			
Reasonable Charges			
8.00	Routine service charges	2,277,268	8.00
9.00	Ancillary service charges	558,526	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)	2,835,794	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)	2,835,794	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	2,388,704	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 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 (enter the lesser of line 4 or line 16)	447,090	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 V or XIX PPS covered services only)	0	28.00
29.00	Titles V or XIX enter the sum of lines 27 and 21.	447,090	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 29 minus lines 5 and 6)	447,090	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)	447,090	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	37.00
38.00	Subtotal (line 36 ± line 37)	447,090	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)	447,090	40.00
41.00	Interim payments	452,706	41.00
42.00	Balance due provider/program (line 40 minus 41)	-5,616	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: 151309

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

Worksheet G

Date/Time Prepared:
1/31/2012 8:54 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	2,156,069	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	6,536,681	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-3,839,905	0	0	0	6.00
7.00	Inventory	443,520	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	10,671	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	5,307,036	0	0	0	11.00
FIXED ASSETS						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	320,447	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	9,000,671	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	9,301,545	0	0	0	19.00
20.00	Accumulated depreciation	-11,844,829	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	6,777,834	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	25,265,121	1,431,322	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	25,265,121	1,431,322	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	37,349,991	1,431,322	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	823,172	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,295,005	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	154,651	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2,272,828	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	8,060,936	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	675,533	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	8,736,469	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	11,009,297	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	26,340,694	0	0	0	52.00
53.00	Specific purpose fund	0	1,431,322	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	Total fund balances (sum of lines 52 thru 58)	26,340,694	1,431,322	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	37,349,991	1,431,322	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151309

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

Worksheet G-1

Date/Time Prepared:
1/31/2012 8:54 am

	General Fund		Special Purpose Fund		
	1.00	2.00	3.00	4.00	
1.00 Fund balances at beginning of period		20,354,084		1,197,114	1.00
2.00 Net income (loss) (from wkst. G-3, line 29)		5,576,214			2.00
3.00 Total (sum of line 1 and line 2)		25,930,298		1,197,114	3.00
4.00 DEFERRED PENSION COSTS	410,395		0		4.00
5.00 CONTRIBUTIONS	0		41,272		5.00
6.00 UNREALIZED GAIN - RESTRICTED HSD	0		78,434		6.00
7.00 UNREALIZED GAIN - RESTRICTED NON-HSD	0		34,668		7.00
8.00 RESTRICTED INVESTMENT INCOME HSD	0		92,222		8.00
9.00 GRANT REVENUE	0		36,609		9.00
10.00 Total additions (sum of line 4-9)		410,395		283,205	10.00
11.00 Subtotal (line 3 plus line 10)		26,340,693		1,480,319	11.00
12.00 RESTRICTED INVESTMENT INCOME NON-HSD	0		7,032		12.00
13.00 NET ASSETS RELEASED FROM RESTRICTION	0		41,965		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		48,997	18.00
19.00 Fund balance at end of period per balance sheet (line 11 minus line 18)		26,340,693		1,431,322	19.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151309

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

Worksheet G-1

Date/Time Prepared:
1/31/2012 8:54 am

	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 CONTRIBUTIONS	0		0		5.00
6.00 UNREALIZED GAIN - RESTRICTED HSD	0		0		6.00
7.00 UNREALIZED GAIN - RESTRICTED NON-HSD	0		0		7.00
8.00 RESTRICTED INVESTMENT INCOME HSD	0		0		8.00
9.00 GRANT REVENUE	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 RESTRICTED INVESTMENT INCOME NON-HSD	0		0		12.00
13.00 NET ASSETS RELEASED FROM RESTRICTION	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: 151309

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

Worksheet G-2 Parts

Date/Time Prepared:
1/31/2012 8:54 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	2,277,268		2,277,268	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	2,277,268		2,277,268	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	2,277,268		2,277,268	17.00
18.00	Ancillary services	6,505,431	46,788,089	53,293,520	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	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to wkst. G-3, line 1)	8,782,699	46,788,089	55,570,788	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per wkst. A, column 3, line 200)		18,543,255		29.00
30.00	BAD DEBTS	4,220,365			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)		4,220,365		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)		22,763,620		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 151309

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

Worksheet G-3

Date/Time Prepared:
1/31/2012 8:54 am

		1.00	
1.00	Total patient revenues (from wkst. G-2, Part I, column 3, line 28)	55,570,788	1.00
2.00	Less contractual allowances and discounts on patients' accounts	31,029,052	2.00
3.00	Net patient revenues (line 1 minus line 2)	24,541,736	3.00
4.00	Less total operating expenses (from wkst. G-2, Part II, line 43)	22,763,620	4.00
5.00	Net income from service to patients (line 3 minus line 4)	1,778,116	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	1,884,412	7.00
8.00	Revenues from telephone and telegraph service	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	36,089	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	7,455	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	180,118	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS INCOME	16,094	24.00
24.01	ASSETS RELEASED FROM RESTRICTION	41,965	24.01
24.02	GRANTS	15,018	24.02
24.03	UNREALIZED GAIN	1,616,947	24.03
25.00	Total other income (sum of lines 6-24)	3,798,098	25.00
26.00	Total (line 5 plus line 25)	5,576,214	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	5,576,214	29.00