

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: 141334	Period: From 04/01/2011 To 03/31/2012	Worksheet S Parts I-III Date/Time Prepared: 8/21/2012 10:22 am
--	----------------------	---	---

PART I - COST REPORT STATUS

Provider use only	1. <input checked="" 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: _____ Time: _____
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 SAINT JOSEPH MEMORIAL HOSPITAL for the cost reporting period beginning 04/01/2011 and ending 03/31/2012 and to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services identified in this cost report were provided in compliance with such laws and regulations.

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

Title

Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	-927,055	619,151	0	0	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
4.00 SUBPROVIDER I	0	0	0	0	0	4.00
5.00 Swing bed - SNF	0	0	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	-927,055	619,151	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 141334		Period: From 04/01/2011 To 03/31/2012		Worksheet S-2 Part I Date/Time Prepared: 8/21/2012 10:22 am				
1.00 Hospital and Hospital Health Care Complex Address:		2.00 PO Box:		3.00 State: IL		4.00 Zip Code: 62966 County: JACKSON				
2.00 Street: 2 SOUTH HOSPITAL DRIVE		2.00 State: IL		3.00 Zip Code: 62966		4.00 County: JACKSON				
2.00 City: MURPHYSBORO		2.00 State: IL		3.00 Zip Code: 62966		4.00 County: JACKSON				
Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00		
3.00 Hospital and Hospital-Based Component Identification:										
3.00 Hospital		SAINT JOSEPH MEMORIAL HOSPITAL	141334	99914	1	05/01/2004	N	O	O	3.00
4.00 Subprovider - IPF										4.00
5.00 Subprovider - IRF										5.00
6.00 Subprovider - (Other)										6.00
7.00 Swing Beds - SNF							N	N	N	7.00
8.00 Swing Beds - NF							N		N	8.00
9.00 Hospital-Based SNF										9.00
10.00 Hospital-Based NF										10.00
11.00 Hospital-Based OLTC										11.00
12.00 Hospital-Based HHA										12.00
13.00 Separately Certified ASC										13.00
14.00 Hospital-Based Hospice										14.00
15.00 Hospital-Based Health Clinic - RHC										15.00
16.00 Hospital-Based Health Clinic - FQHC										16.00
17.00 Hospital-Based (CMHC) 1										17.00
18.00 Renal Dialysis										18.00
19.00 Other										19.00
		From:		To:						
		1.00		2.00						
20.00 Cost Reporting Period (mm/dd/yyyy)		04/01/2011		03/31/2012					20.00	
21.00 Type of Control (see instructions)				2					21.00	
22.00 Inpatient PPS Information										
22.00 Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.				N		N			22.00	
23.00 Indicate in column 1 the method used to capture Medicaid (title XIX) days reported on lines 24 and/or 25 of this worksheet during the cost reporting period by entering a "1" if days are based on the date of admission, "2" if days are based on census days (also referred to as the day count), or "3" if the days are based on the date of discharge. Is the method of identifying the days in the current cost reporting period different from the method used in the prior cost reporting period? Enter in column 2 "Y" for yes or "N" for no.						3			N	23.00
		In-State Medicaid paid days	In-State Medicaid eligible unpaid 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 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 paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.		0	0	0	0	0	0		24.00	
25.00 If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible days in col. 2, out-of-state Medicaid eligible days in col. 3, out-of-state Medicaid eligible days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.		0	0	0	0	0	0		25.00	
		Urban/Rural		S		Date of Geogr				
		1.00		2.00						
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 For the Standard Geographic classification (not wage), what is your status at the end of the cost reporting period. Enter (1) for urban or (2) for rural. If applicable, enter the effective date of the geographic reclassification in column 2.						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		
37.00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.						0		37.00		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 141334	Period: From 04/01/2011 To 03/31/2012	Worksheet S-2 Part I Date/Time Prepared: 8/21/2012 10:22 am		
		Beginning:	Ending:			
		1.00	2.00			
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.				38.00	
		V	XVIII	XIX		
		1.00	2.00	3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00	
46.00	Is this facility eligible for the special exceptions payment pursuant to 42 CFR Section §412.348(g)? If yes, complete Worksheet L, Part III and L-1, Parts I through III	N	N	N	46.00	
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N	47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00	
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.				57.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.				58.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59.00	
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00	
		Y/N	IME Average	Direct GME Average		
		1.00	2.00	3.00		
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)	N	0.00	0.00	61.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00			62.00	
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00			62.01	
Teaching Hospitals that Claim Residents in Non-Provider Settings						
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)	N			63.00	
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
		1.00	2.00	3.00		
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. If line 63 is yes or your facility trained residents in the base year period, enter in column 1, from your cost reporting period that begins on or after July 1, 2009, and before June 30, 2010 the number of unweighted nonprimary care FTE residents attributable to rotations that occurred in all nonprovider settings. Enter in column 2 the number of unweighted nonprimary care FTE residents that trained in your hospital. Include unweighted OB/GYN, dental and podiatry FTEs on this line. Enter in column 3, the ratio of column 1 divided by the sum of columns 1 and 2.	0.00	0.00	0.000000	64.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))
		1.00	2.00	3.00	4.00	5.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 141334

Period:
From 04/01/2011
To 03/31/2012

Worksheet S-2
Part I
Date/Time Prepared:
8/21/2012 10:22 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	If line 63 is yes or your facility trained residents in the base year period, enter from your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010, the number of unweighted primary care FTE residents for each primary care specialty program in which you train residents. Use subscripted lines 65.01 through 65.50 for each additional primary care program. 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 that occurred in nonprovider settings for each applicable program. Enter in column 4, the number of unweighted primary care FTE residents in your hospital for each applicable program. Enter in column 5 the ratio of column 3 divided by the sum of columns 3 and 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	If line 63 is yes, then, for each primary care residency program in which you are training residents, 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 that occurred in nonprovider settings for each applicable program. Enter in column 4 the number of unweighted primary care FTE residents in your hospital for each applicable program. Enter in column 5 the ratio of column 3 divided by the sum of columns 3 and 4. Use subscripted lines 67.01 through 67.50 for each additional primary care program. If you operated a primary care program that did not have FTE residents in a nonprovider setting, enter zero in column 3 and complete all other columns for each applicable program.			0.00	0.00	0.000000	67.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 141334	Period: From 04/01/2011 To 03/31/2012	Worksheet S-2 Part I Date/Time Prepared: 8/21/2012 10:22 am	
			1.00	2.00	3.00
Inpatient Psychiatric Facility PPS					
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			0	71.00
Inpatient Rehabilitation Facility PPS					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			0	76.00
			1.00		
Long Term Care Hospital PPS					
80.00	Are you a long term care hospital (LTCH)? Enter in column 1 "Y" for yes and "N" for no. LTCHs can only exist as independent/freestanding facilities. An independent or freestanding facility may exist as an unrelated hospital within a hospital, it must meet the separateness (from the host/co-located provider) requirements identified in 42 CFR 412.22(e.)			N	80.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			N	86.00
			V	XIX	
			1.00	2.00	
Title V or XIX Inpatient Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N		Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N		N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N		N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N		N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	97.00
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	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N
				1.00	2.00
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2.	N			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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 141334	Period: From 04/01/2011 To 03/31/2012	Worksheet S-2 Part I Date/Time Prepared: 8/21/2012 10:22 am	
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	Enter the total amount of malpractice premiums paid in column 1, enter the total amount of paid losses in column 2, and enter the total amount of self insurance paid in column 3.	820,881	0	0	
		1.00	2.00		
118.02	Indicate if malpractice premiums and paid losses are reported in other than the Administrative and General cost center. If yes, provide a supporting schedule and list the amounts applicable to each cost center.	N		118.02	
119.00	DO NOT USE THIS LINE			119.00	
120.00	If this is an SCH (or EACH), regardless of bed size, or is rural hospital with 100 or fewer beds that qualifies for the outpatient hold harmless provision in accordance with ACA, section 3121, as amended by the Medicare and Medicaid Extenders Act (MMEA) of 2010, section 108; the Temporary Payroll Tax Cut Continuation Act of 2011, section 308; and the Middle Class Tax Relief and Job Creation Act of 2012, section 3002, enter "Y" for yes or "N" for no in column 1 or column 2, respectively. Note that for SCHs (and EACHs) the outpatient hold harmless provision is effective for services rendered from January 1, 2010 through February 29, 2012 regardless of bed size and from March 1, 2012 through December 31, 2012 to all SCHs (and EACHs) with 100 or fewer beds. These responses impact the TOPs calculation on Worksheet E, Part B, line 8.	N		120.00	
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00	
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00	
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00	
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00	
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00	
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00	
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00	
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00	
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00	
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00	
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		14H124	
		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: SOUTHERN ILLINOIS HEALTHCARE	Contractor's Name: NGS		Contractor's Number: 00131	
142.00	Street: 1239 E. MAIN ST.	PO Box: 3988			
143.00	City: CARBONDALE	State: IL		Zip Code: 62902-3988	
				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, line 74, 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	Title V	Title XIX
		1.00	2.00	3.00	4.00
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	N	N
156.00	Subprovider - IPF	N	N	N	N
157.00	Subprovider - IRF	N	N	N	N
158.00	SUBPROVIDER	N	N	N	N
159.00	SNF	N	N	N	N

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 141334		Period: From 04/01/2011 To 03/31/2012		Worksheet S-2 Part I Date/Time Prepared: 8/21/2012 10:22 am		
		Part A	Part B	Title V	Title XIX			
		1.00	2.00	3.00	4.00			
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00		
161.00	CMHC		N	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: 141334	Period: From 04/01/2011 To 03/31/2012	Worksheet S-2 Part II Date/Time Prepared: 8/21/2012 10:22 am
		Y/N	Date	
		1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N	Date	V/I
		1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y		3.00
		Y/N	Type	Date
		1.00	2.00	3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	Y		5.00
		Y/N	Legal Oper.	
		1.00	2.00	
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N		9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
		Y/N		
		1.00		
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N	14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N	15.00
		Part A		
		Description	Y/N	Date
		0	1.00	2.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	07/31/2012	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 141334	Period: From 04/01/2011 To 03/31/2012	Worksheet S-2 Part II Date/Time Prepared: 8/21/2012 10:22 am
---	--	----------------------	---	---

		Part A			
		Description	Y/N	Date	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	0	1.00 N	2.00	21.00
					1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions		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.		Y		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		Y		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		Y		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N		33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		Y		35.00
					Y/N
					Date
					1.00
					2.00
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
					1.00
					2.00
					3.00
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	LUANNE	WARREN	REIMBURSEMENT MANAGER	41.00
42.00	Enter the employer/company name of the cost report preparer.	SOUTHERN ILLINOIS HEALTHCARE			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	618-457-5200, 67202	LUANNE.WARREN@SIH.NET		43.00

		Part B		
		Y/N	Date	
PS&R Data		3.00	4.00	
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	07/31/2012	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: 141334

Period:
From 04/01/2011
To 03/31/2012

Worksheet S-3
Part I
Date/Time Prepared:
8/21/2012 10:22 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	9,150	72,531.35	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	9,150	72,531.35	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	9,150	72,531.35	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: 141334

Period:
From 04/01/2011
To 03/31/2012

Worksheet S-3
Part I
Date/Time Prepared:
8/21/2012 10:22 am

Cost Center Description	I/P Days / O/P Visits / Trips					
	Title V	Title XVIII	Title XIX	Total All Patients		
	5.00	6.00	7.00	8.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	0	2,072	385	2,998		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	0	0	0		5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0		0	0		6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	0	2,072	385	2,998		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	2,072	385	2,998		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		147	973		28.00
29.00 Ambulance Trips		0				29.00
30.00 Employee discount days (see instruction)				0		30.00
31.00 Employee discount days - IRF				0		31.00
32.00 Labor & delivery days (see instructions)			0	0		32.00
33.00 LTCH non-covered days		0				33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 141334

Period:
From 04/01/2011
To 03/31/2012

Worksheet S-3
Part I
Date/Time Prepared:
8/21/2012 10:22 am

Cost Center Description	Full Time Equivalents			Discharges		
	Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	
	9.00	10.00	11.00	12.00	13.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)				0	601	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	219.63	0.00	0	601	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	219.63	0.00			27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 141334

Period:
From 04/01/2011
To 03/31/2012

Worksheet S-3
Part I
Date/Time Prepared:
8/21/2012 10:22 am

Cost Center Description	Discharges			
	Title XIX	Total All Patients		
	14.00	15.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	136	931		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)	136	931		14.00
15.00 CAH visits				15.00
16.00 SUBPROVIDER - IPF				16.00
17.00 SUBPROVIDER - IRF				17.00
18.00 SUBPROVIDER				18.00
19.00 SKILLED NURSING FACILITY				19.00
20.00 NURSING FACILITY				20.00
21.00 OTHER LONG TERM CARE				21.00
22.00 HOME HEALTH AGENCY				22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)				23.00
24.00 HOSPICE				24.00
25.00 CMHC - CMHC				25.00
26.00 RURAL HEALTH CLINIC				26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER				26.25
27.00 Total (sum of lines 14-26)				27.00
28.00 Observation Bed Days				28.00
29.00 Ambulance Trips				29.00
30.00 Employee discount days (see instruction)				30.00
31.00 Employee discount days - IRF				31.00
32.00 Labor & delivery days (see instructions)				32.00
33.00 LTCH non-covered days				33.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 141334	Period: From 04/01/2011 To 03/31/2012	Worksheet S-10 Date/Time Prepared: 8/21/2012 10:22 am
---	----------------------	---	---

				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)		0.324553		1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		3,655,775		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y		3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		N		4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		370,755		5.00
6.00	Medicaid charges		18,998,867		6.00
7.00	Medicaid cost (line 1 times line 6)		6,166,139		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)		2,139,609		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		31,530		18.00
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		2,139,609		19.00
				1.00	
				2.00	
				3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	2,783,873	393,884	3,177,757	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	903,514	127,836	1,031,350	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)	903,514	127,836	1,031,350	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)		4,838,583		26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		1,381,860		27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)		3,456,723		28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)		1,121,890		29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)		2,153,240		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		4,292,849		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 141334

Period:
From 04/01/2011
To 03/31/2012

Worksheet A
Date/Time Prepared:
8/21/2012 10:22 am

Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
	1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS						
1.00 CAP REL COSTS-BLDG & FIXT		1,143,400	1,143,400	158,620	1,302,020	1.00
2.00 CAP REL COSTS-MVBLE EQUIP		1,084,241	1,084,241	93,158	1,177,399	2.00
3.00 OTHER CAP REL COSTS		0	0	0	0	3.00
4.00 EMPLOYEE BENEFITS	126,174	3,781,837	3,908,011	0	3,908,011	4.00
5.01 DATA PROCESSING	0	0	0	0	0	5.01
5.02 PURCHASING RECEIVING AND STORES	28,049	31,884	59,933	0	59,933	5.02
5.03 CASHIERING/ACCOUNTS RECEIVABLE	426,353	27,352	453,705	0	453,705	5.03
5.04 OTHER ADMINISTRATIVE AND GENERAL	744,414	1,961,639	2,706,053	-33,102	2,672,951	5.04
6.00 MAINTENANCE & REPAIRS	314,124	524,710	838,834	0	838,834	6.00
7.00 OPERATION OF PLANT	87,681	1,084	88,765	0	88,765	7.00
8.00 LAUNDRY & LINEN SERVICE	0	77,423	77,423	0	77,423	8.00
9.00 HOUSEKEEPING	245,138	48,061	293,199	0	293,199	9.00
10.00 DIETARY	335,020	109,956	444,976	-320,500	124,476	10.00
11.00 CAFETERIA	0	0	0	319,687	319,687	11.00
13.00 NURSING ADMINISTRATION	769,025	92,569	861,594	0	861,594	13.00
14.00 CENTRAL SERVICES & SUPPLY	393	24,132	24,525	0	24,525	14.00
15.00 PHARMACY	325,393	4,449,277	4,774,670	0	4,774,670	15.00
16.00 MEDICAL RECORDS & LIBRARY	57,128	3,998	61,126	0	61,126	16.00
17.00 SOCIAL SERVICE	28,451	383	28,834	0	28,834	17.00
19.00 NONPHYSICIAN ANESTHETISTS	0	0	0	167,884	167,884	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	2,149,174	347,933	2,497,107	-12,853	2,484,254	30.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	1,112,969	1,255,214	2,368,183	-739,487	1,628,696	50.00
51.00 RECOVERY ROOM	152,543	4,885	157,428	-174	157,254	51.00
53.00 ANESTHESIOLOGY	0	220,838	220,838	-176,132	44,706	53.00
54.00 RADIOLOGY-DIAGNOSTIC	857,346	809,260	1,666,606	-31	1,666,575	54.00
60.00 LABORATORY	711,184	1,386,744	2,097,928	-89	2,097,839	60.00
64.00 INTRAVENOUS THERAPY	502,352	258,599	760,951	-1,035	759,916	64.00
65.00 RESPIRATORY THERAPY	393,589	78,099	471,688	-32,354	439,334	65.00
65.01 SLEEP DISORDERS	1,172,384	360,484	1,532,868	0	1,532,868	65.01
65.02 GERIATRIC PSYCH	0	427,940	427,940	0	427,940	65.02
66.00 PHYSICAL THERAPY	295,254	129,446	424,700	-465	424,235	66.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	598,895	598,895	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	184,179	184,179	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	15,312	15,312	73.00
76.97 CARDIAC REHABILITATION	271,430	15,767	287,197	-305	286,892	76.97
OUTPATIENT SERVICE COST CENTERS						
91.00 EMERGENCY	1,039,563	1,071,697	2,111,260	-2,532	2,108,728	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS						
113.00 INTEREST EXPENSE		502,124	502,124	-218,676	283,448	113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	12,145,131	20,230,976	32,376,107	0	32,376,107	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	14,350	14,350	0	14,350	192.00
192.01 UNUSED SPACE	0	0	0	0	0	192.01
200.00 TOTAL (SUM OF LINES 118-199)	12,145,131	20,245,326	32,390,457	0	32,390,457	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 141334

Period:
From 04/01/2011
To 03/31/2012

Worksheet A
Date/Time Prepared:
8/21/2012 10:22 am

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
		6.00	7.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	7,590	1,309,610	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	706,261	1,883,660	2.00
3.00	OTHER CAP REL COSTS	0	0	3.00
4.00	EMPLOYEE BENEFITS	-204,038	3,703,973	4.00
5.01	DATA PROCESSING	1,047,965	1,047,965	5.01
5.02	PURCHASING RECEIVING AND STORES	-3,420	56,513	5.02
5.03	CASHIERING/ACCOUNTS RECEIVABLE	644,179	1,097,884	5.03
5.04	OTHER ADMINISTRATIVE AND GENERAL	714,624	3,387,575	5.04
6.00	MAINTENANCE & REPAIRS	0	838,834	6.00
7.00	OPERATION OF PLANT	0	88,765	7.00
8.00	LAUNDRY & LINEN SERVICE	0	77,423	8.00
9.00	HOUSEKEEPING	0	293,199	9.00
10.00	DIETARY	0	124,476	10.00
11.00	CAFETERIA	-85,041	234,646	11.00
13.00	NURSING ADMINISTRATION	0	861,594	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	24,525	14.00
15.00	PHARMACY	0	4,774,670	15.00
16.00	MEDICAL RECORDS & LIBRARY	-18,052	43,074	16.00
17.00	SOCIAL SERVICE	0	28,834	17.00
19.00	NONPHYSICIAN ANESTHETISTS	-167,884	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	0	2,484,254	30.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0	1,628,696	50.00
51.00	RECOVERY ROOM	0	157,254	51.00
53.00	ANESTHESIOLOGY	0	44,706	53.00
54.00	RADIOLOGY-DIAGNOSTIC	-473	1,666,102	54.00
60.00	LABORATORY	0	2,097,839	60.00
64.00	INTRAVENOUS THERAPY	0	759,916	64.00
65.00	RESPIRATORY THERAPY	0	439,334	65.00
65.01	SLEEP DISORDERS	-1,054	1,531,814	65.01
65.02	GERIATRIC PSYCH	0	427,940	65.02
66.00	PHYSICAL THERAPY	0	424,235	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	598,895	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	184,179	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	15,312	73.00
76.97	CARDIAC REHABILITATION	-30,991	255,901	76.97
OUTPATIENT SERVICE COST CENTERS				
91.00	EMERGENCY	-800,834	1,307,894	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
SPECIAL PURPOSE COST CENTERS				
113.00	INTEREST EXPENSE	-283,448	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	1,525,384	33,901,491	118.00
NONREIMBURSABLE COST CENTERS				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	-6,729	7,621	192.00
192.01	UNUSED SPACE	0	0	192.01
200.00	TOTAL (SUM OF LINES 118-199)	1,518,655	33,909,112	200.00

RECLASSIFICATIONS

Provider CCN: 141334

Period:
From 04/01/2011
To 03/31/2012

Worksheet A-6

Date/Time Prepared:
8/21/2012 10:22 am

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - DIETARY RECLASS					
1.00	CAFETERIA	11.00	241,131	79,141	1.00
	TOTALS		241,131	79,141	
B - MEDICAL SUPPLY RECLASS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	783,074	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
	TOTALS		0	783,074	
C - INSURANCE RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	20,854	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	12,248	2.00
	TOTALS		0	33,102	
D - IV SOLUTIONS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	15,312	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
	TOTALS		0	15,312	
E - INTEREST RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	137,766	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	80,910	2.00
	TOTALS		0	218,676	
F - IMPLANTABLE DEVICE RECLASS					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	184,179	1.00
	TOTALS		0	184,179	
G - CRNA RECLASS					
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	167,884	1.00
	TOTALS		0	167,884	
500.00	Grand Total: Increases		241,131	1,481,368	500.00

RECLASSIFICATIONS

Provider CCN: 141334

Period:
From 04/01/2011
To 03/31/2012

Worksheet A-6

Date/Time Prepared:
8/21/2012 10:22 am

		Decreases				Wkst. A-7 Ref.	
Cost Center	Line #	Salary	Other				
6.00	7.00	8.00	9.00	10.00			
A - DIETARY RECLASS							
1.00	DIETARY	10.00	241,131	79,141	0		1.00
	TOTALS		241,131	79,141			
B - MEDICAL SUPPLY RECLASS							
1.00	OPERATING ROOM	50.00	0	735,905	0		1.00
2.00	ANESTHESIOLOGY	53.00	0	7,937	0		2.00
3.00	RESPIRATORY THERAPY	65.00	0	32,354	0		3.00
4.00	EMERGENCY	91.00	0	679	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	5,340	0		5.00
6.00	PHYSICAL THERAPY	66.00	0	465	0		6.00
7.00	CARDIAC REHABILITATION	76.97	0	305	0		7.00
8.00	LABORATORY	60.00	0	89	0		8.00
	TOTALS		0	783,074			
C - INSURANCE RECLASS							
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	33,102	9		1.00
2.00		0.00	0	0	9		2.00
	TOTALS		0	33,102			
D - IV SOLUTIONS							
1.00	DIETARY	10.00	0	228	0		1.00
2.00	CAFETERIA	11.00	0	585	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	7,513	0		3.00
4.00	OPERATING ROOM	50.00	0	3,582	0		4.00
5.00	RECOVERY ROOM	51.00	0	174	0		5.00
6.00	ANESTHESIOLOGY	53.00	0	311	0		6.00
7.00	EMERGENCY	91.00	0	1,853	0		7.00
8.00	INTRAVENOUS THERAPY	64.00	0	1,035	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	31	0		9.00
	TOTALS		0	15,312			
E - INTEREST RECLASS							
1.00	INTEREST EXPENSE	113.00	0	218,676	9		1.00
2.00		0.00	0	0	9		2.00
	TOTALS		0	218,676			
F - IMPLANTABLE DEVICE RECLASS							
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	184,179	0		1.00
	TOTALS		0	184,179			
G - CRNA RECLASS							
1.00	ANESTHESIOLOGY	53.00	0	167,884	0		1.00
	TOTALS		0	167,884			
500.00	Grand Total: Decreases		241,131	1,481,368			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141334

Period:
From 04/01/2011
To 03/31/2012

Worksheet A-7
Parts I-III
Date/Time Prepared:
8/21/2012 10:22 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	171,136	0	0	0	0	1.00
2.00	Land Improvements	851,377	27,150	0	27,150	4,964	2.00
3.00	Buildings and Fixtures	17,296,147	1,083,040	0	1,083,040	84,973	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	10,526,187	1,014,851	0	1,014,851	277,732	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	28,844,847	2,125,041	0	2,125,041	367,669	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	28,844,847	2,125,041	0	2,125,041	367,669	10.00
SUMMARY OF CAPITAL							
Cost Center Description		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	1,143,400	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,084,241	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,227,641	0	0	0	0	3.00
COMPUTATION OF RATIOS							
Cost Center Description		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	20,309,127	0	20,309,127	0.643255	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	11,263,307	0	11,263,307	0.356745	0	2.00
3.00	Total (sum of lines 1-2)	31,572,434	0	31,572,434	1.000000	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141334

Period:
From 04/01/2011
To 03/31/2012

Worksheet A-7
Parts I-III
Date/Time Prepared:
8/21/2012 10:22 am

		Ending Balance	Fully Depreciated Assets			
		6.00	7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	171,136	0		1.00	
2.00	Land Improvements	873,563	0		2.00	
3.00	Buildings and Fixtures	18,294,214	0		3.00	
4.00	Building Improvements	0	0		4.00	
5.00	Fixed Equipment	0	0		5.00	
6.00	Movable Equipment	11,263,306	0		6.00	
7.00	HIT designated Assets	0	0		7.00	
8.00	Subtotal (sum of lines 1-7)	30,602,219	0		8.00	
9.00	Reconciling Items	0	0		9.00	
10.00	Total (line 8 minus line 9)	30,602,219	0		10.00	
SUMMARY OF CAPITAL						
Cost Center Description		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)			
		14.00	15.00			
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	1,143,400		1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,084,241		2.00	
3.00	Total (sum of lines 1-2)	0	2,227,641		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	1,309,610	0
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,883,660	0
3.00	Total (sum of lines 1-2)	0	0	0	3,193,270	0

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141334

Period:
From 04/01/2011
To 03/31/2012

Worksheet A-7
Parts I-III
Date/Time Prepared:
8/21/2012 10:22 am

Cost Center Description	SUMMARY OF CAPITAL					Total (2) (sum of cols. 9 through 14)	
	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
	11.00	12.00	13.00	14.00	15.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	1,309,610	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	1,883,660	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	3,193,270	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 141334

Period:
From 04/01/2011
To 03/31/2012

Worksheet A-8

Date/Time Prepared:
8/21/2012 10:22 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
			Cost Center		Line #	
			1.00	2.00	3.00	4.00
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			OCAP REL COSTS-BLDG & FIXT		1.00	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			OCAP REL COSTS-MVBLE EQUIP		2.00	2.00
3.00 Investment income - other (chapter 2)		0			0.00	3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0			0.00	4.00
5.00 Refunds and rebates of expenses (chapter 8)		0			0.00	5.00
6.00 Rental of provider space by suppliers (chapter 8)		0			0.00	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0			0.00	7.00
8.00 Television and radio service (chapter 21)		0			0.00	8.00
9.00 Parking lot (chapter 21)		0			0.00	9.00
10.00 Provider-based physician adjustment	A-8-2	-831,687				
11.00 Sale of scrap, waste, etc. (chapter 23)		0			0.00	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	5,021,772				12.00
13.00 Laundry and linen service		0			0.00	13.00
14.00 Cafeteria-employees and guests	B	-76,771	CAFETERIA		11.00	14.00
15.00 Rental of quarters to employee and others		0			0.00	15.00
16.00 Sale of medical and surgical supplies to other than patients		0			0.00	16.00
17.00 Sale of drugs to other than patients		0			0.00	17.00
18.00 Sale of medical records and abstracts	B	-18,052	MEDICAL RECORDS & LIBRARY		16.00	18.00
19.00 Nursing school (tuition, fees, books, etc.)		0			0.00	19.00
20.00 Vending machines	B	-8,270	CAFETERIA		11.00	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		ORESPIRATORY THERAPY		65.00	23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		OPHYSICAL THERAPY		66.00	24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0*** Cost Center Deleted ***		114.00	25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT			OCAP REL COSTS-BLDG & FIXT		1.00	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			OCAP REL COSTS-MVBLE EQUIP		2.00	27.00
28.00 Non-physician Anesthetist	A	-167,884	NONPHYSICIAN ANESTHETISTS		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*** Cost Center Deleted ***		68.00	31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0			0.00	32.00
33.00 PURCHASE DISCOUNT	B	-3,420	PURCHASING RECEIVING AND STORES		5.02	33.00
34.00 EMPLOYEE OUTPATIENT INSURANCE PYMNTS	B	-1,094,184	EMPLOYEE BENEFITS		4.00	34.00
35.00 LOBBYING EXPENSES	A	-10,490	OTHER ADMINISTRATIVE AND GENERAL		5.04	35.00
36.00 UNRESTRCTED INTEREST REVENUE	B	-191,786	OTHER ADMINISTRATIVE AND GENERAL		5.04	36.00
37.00 PERSONAL USE OF PROVIDER VEHICLES	A	-9,378	OTHER ADMINISTRATIVE AND GENERAL		5.04	37.00
38.00 LEASEHOLD REVENUE	B	-24,942	CAP REL COSTS-BLDG & FIXT		1.00	38.00
39.00 DONATIONS	A	-1,370	OTHER ADMINISTRATIVE AND GENERAL		5.04	39.00
40.00 XRAY FILM REVENUE	B	-473	RADIOLOGY-DIAGNOSTIC		54.00	40.00
41.00 LOAN FORGIVENESS	A	-485,653	OTHER ADMINISTRATIVE AND GENERAL		5.04	41.00
42.00 NONALLOWABLE INTEREST EXPENSE	A	-283,448	INTEREST EXPENSE		113.00	42.00
43.00 REAL ESTATE TAXES	A	-6,729	PHYSICIANS' PRIVATE OFFICES		192.00	43.00
44.00 MEDICAID PROVIDER TAX	A	-287,388	OTHER ADMINISTRATIVE AND GENERAL		5.04	44.00
45.00 CABLE TV	A	-7	SLEEP DISORDERS		65.01	45.00
46.00 REAL ESTATE TAXES	A	-1,047	SLEEP DISORDERS		65.01	46.00
47.00 CVP PROFESSIONAL FEES	A	-138	CARDIAC REHABILITATION		76.97	47.00

Provider CCN: 141334	Period: From 04/01/2011 To 03/31/2012	Worksheet A-8 Date/Time Prepared: 8/21/2012 10:22 am
----------------------	---	--

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		
			Cost Center	Line #	
	1.00	2.00	3.00	4.00	
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		1,518,655			50.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 141334

Period:
From 04/01/2011
To 03/31/2012

Worksheet A-8

Date/Time Prepared:
8/21/2012 10:22 am

Cost Center Description		Wkst. A-7 Ref.	
		5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	0	2.00
3.00	Investment income - other (chapter 2)	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	0	7.00
8.00	Television and radio service (chapter 21)	0	8.00
9.00	Parking lot (chapter 21)	0	9.00
10.00	Provider-based physician adjustment	0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	0	11.00
12.00	Related organization transactions (chapter 10)	0	12.00
13.00	Laundry and linen service	0	13.00
14.00	Cafeteria-employees and guests	0	14.00
15.00	Rental of quarters to employee and others	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	0	16.00
17.00	Sale of drugs to other than patients	0	17.00
18.00	Sale of medical records and abstracts	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)	0	19.00
20.00	Vending machines	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	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	PURCHASE DISCOUNT	0	33.00
34.00	EMPLOYEE OUTPATIENT INSURANCE PYMNTS	0	34.00
35.00	LOBBYING EXPENSES	0	35.00
36.00	UNRESTRICTED INTEREST REVENUE	0	36.00
37.00	PERSONAL USE OF PROVIDER VEHICLES	0	37.00
38.00	LEASEHOLD REVENUE	9	38.00
39.00	DONATIONS	0	39.00
40.00	XRAY FILM REVENUE	0	40.00
41.00	LOAN FORGIVENESS	0	41.00
42.00	NONALLOWABLE INTEREST EXPENSE	0	42.00
43.00	REAL ESTATE TAXES	0	43.00
44.00	MEDI CAID PROVIDER TAX	0	44.00
45.00	CABLE TV	0	45.00
46.00	REAL ESTATE TAXES	0	46.00
47.00	CVP PROFESSIONAL FEES	0	47.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		50.00

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

Provider CCN: 141334

Period:
From 04/01/2011
To 03/31/2012

Worksheet A-8-1

Date/Time Prepared:
8/21/2012 10:22 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	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE	2.00
3.00	4.00	EMPLOYEE BENEFITS	HOME OFFICE	3.00
4.00	5.01	DATA PROCESSING	HOME OFFICE	4.00
4.01	5.03	CASHIERING/ACCOUNTS RECEIVABLE	HOME OFFICE	4.01
4.02	5.04	OTHER ADMINISTRATIVE AND GENERAL	HOME OFFICE	4.02
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			5.00

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

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

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

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

6.00	B	SO I L HOSP SVCS	100.00	6.00
7.00	B	SI HE	100.00	7.00
8.00	B	HSSI	100.00	8.00
9.00	B	SO I L MED SVCS	100.00	9.00
10.00			0.00	10.00
100.00	G. Other (financial or non-financial) specify:			100.00

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

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

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

Provider CCN: 141334

Period: From 04/01/2011 To 03/31/2012

Worksheet A-8-1

Date/Time Prepared: 8/21/2012 10:22 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
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00	32,532	0	32,532	9	1.00	
2.00	706,261	0	706,261	9	2.00	
3.00	890,146	0	890,146	0	3.00	
4.00	1,047,965	0	1,047,965	0	4.00	
4.01	644,179	0	644,179	0	4.01	
4.02	1,700,689	0	1,700,689	0	4.02	
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.	5,021,772	0	5,021,772		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	SO IL HOSP SVCS	100.00	HEALTHCARE	6.00
7.00	SO IL HEALTHCAR	100.00	HEALTHCARE	7.00
8.00	HEALTH SVCS. OF	100.00	HEALTHCARE	8.00
9.00	SO IL MED SVCS	100.00	HEALTHCARE	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: 141334

Period:
From 04/01/2011
To 03/31/2012

Worksheet A-8-2

Date/Time Prepared:
8/21/2012 10:22 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	800,834	800,834	1.00
2.00	60.00	LABORATORY	40,000	0	2.00
3.00	76.97	CARDIAC REHABILITATION	32,998	30,853	3.00
4.00	65.01	SLEEP DISORDERS	26,400	0	4.00
5.00	64.00	INTRAVENOUS THERAPY	440	0	5.00
6.00	65.00	RESPIRATORY THERAPY	424	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			901,096	831,687	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 141334

Period:
From 04/01/2011
To 03/31/2012

Worksheet A-8-2

Date/Time Prepared:
8/21/2012 10:22 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	0	0	0	0	0	1.00
2.00	40,000	0	0	0	0	2.00
3.00	2,145	0	0	0	0	3.00
4.00	26,400	0	0	0	0	4.00
5.00	440	0	0	0	0	5.00
6.00	424	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	69,409					200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 141334

Period:
From 04/01/2011
To 03/31/2012

Worksheet A-8-2

Date/Time Prepared:
8/21/2012 10:22 am

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 141334

Period:
From 04/01/2011
To 03/31/2012

Worksheet A-8-2

Date/Time Prepared:
8/21/2012 10:22 am

	RCE	Adjustment	
	Disallowance		
	17.00	18.00	
1.00	0	800,834	1.00
2.00	0	0	2.00
3.00	0	30,853	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	831,687	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141334

Period:
From 04/01/2011
To 03/31/2012

Worksheet B
Part I
Date/Time Prepared:
8/21/2012 10:22 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	DATA PROCESSING	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	1,309,610	1,309,610			1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,883,660		1,883,660		2.00
4.00	EMPLOYEE BENEFITS	3,703,973	5,158	7,419	3,716,550	4.00
5.01	DATA PROCESSING	1,047,965	4,326	6,222	0	1,058,513
5.02	PURCHASING RECEIVING AND STORES	56,513	4,311	6,200	8,673	8,468
5.03	CASHIERING/ACCOUNTS RECEIVABLE	1,097,884	14,732	21,190	131,839	50,809
5.04	OTHER ADMINISTRATIVE AND GENERAL	3,387,575	303,641	436,739	230,191	80,447
6.00	MAINTENANCE & REPAIRS	838,834	41,534	59,740	97,135	4,234
7.00	OPERATION OF PLANT	88,765	78,606	113,062	27,113	0
8.00	LAUNDRY & LINEN SERVICE	77,423	11,979	17,230	0	0
9.00	HOUSEKEEPING	293,199	2,148	3,089	75,803	12,702
10.00	DIETARY	124,476	46,843	67,376	29,033	12,702
11.00	CAFETERIA	234,646	32,156	46,252	74,563	0
13.00	NURSING ADMINISTRATION	861,594	37,420	53,823	237,801	122,788
14.00	CENTRAL SERVICES & SUPPLY	24,525	9,317	13,401	122	0
15.00	PHARMACY	4,774,670	14,596	20,994	100,619	21,170
16.00	MEDICAL RECORDS & LIBRARY	43,074	65,931	94,831	17,665	29,638
17.00	SOCIAL SERVICE	28,834	7,139	10,268	8,798	4,234
19.00	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	2,484,254	168,012	241,658	664,575	139,724
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	1,628,696	112,154	161,315	344,157	80,447
51.00	RECOVERY ROOM	157,254	11,979	17,230	47,170	8,468
53.00	ANESTHESIOLOGY	44,706	1,180	1,697	0	12,702
54.00	RADIOLOGY-DIAGNOSTIC	1,666,102	59,987	86,281	265,112	80,447
60.00	LABORATORY	2,097,839	37,980	54,628	219,915	76,213
64.00	INTRAVENOUS THERAPY	759,916	16,850	24,235	155,339	46,575
65.00	RESPIRATORY THERAPY	439,334	10,164	14,620	121,707	33,872
65.01	SLEEP DISORDERS	1,531,814	64,767	93,156	362,529	76,213
65.02	GERIATRIC PSYCH	427,940	18,589	26,737	0	21,170
66.00	PHYSICAL THERAPY	424,235	0	0	91,300	42,341
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	598,895	0	0	0	0
72.00	IMPL. DEV. CHARGED TO PATIENTS	184,179	0	0	0	0
73.00	DRUGS CHARGED TO PATIENTS	15,312	0	0	0	0
76.97	CARDIAC REHABILITATION	255,901	26,817	38,572	83,933	16,936
OUTPATIENT SERVICE COST CENTERS						
91.00	EMERGENCY	1,307,894	62,135	89,371	321,458	76,213
92.00	OBSERVATION BEDS (NON-DISTINCT PART)					
SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE					
118.00	SUBTOTALS (SUM OF LINES 1-117)	33,901,491	1,270,451	1,827,336	3,716,550	1,058,513
NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6,519	9,377	0	0
192.00	PHYSICIANS' PRIVATE OFFICES	7,621	13,446	19,340	0	0
192.01	UNUSED SPACE	0	19,194	27,607	0	0
200.00	Cross Foot Adjustments					
201.00	Negative Cost Centers		0	0	0	0
202.00	TOTAL (sum lines 118-201)	33,909,112	1,309,610	1,883,660	3,716,550	1,058,513

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141334

Period:
From 04/01/2011
To 03/31/2012

Worksheet B
Part I
Date/Time Prepared:
8/21/2012 10:22 am

Cost Center Description	PURCHASING RECEIVING AND STORES	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	
	5.02	5.03	5A.03	5.04	6.00	
GENERAL SERVICE COST CENTERS						
1.00						1.00
2.00						2.00
4.00						4.00
5.01						5.01
5.02	84,165					5.02
5.03	977	1,317,431				5.03
5.04	0	0	4,438,593	4,438,593		5.04
6.00	0	0	1,041,477	156,858	1,198,335	6.00
7.00	0	0	307,546	46,320	100,647	7.00
8.00	0	0	106,632	16,060	15,338	8.00
9.00	3	0	386,944	58,278	2,750	9.00
10.00	35	0	280,465	42,241	59,978	10.00
11.00	91	0	387,708	58,393	41,173	11.00
13.00	3	0	1,313,429	197,817	47,912	13.00
14.00	163	0	47,528	7,158	11,930	14.00
15.00	0	0	4,932,049	742,830	18,689	15.00
16.00	0	0	251,139	37,824	84,418	16.00
17.00	0	0	59,273	8,927	9,141	17.00
19.00	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	13,566	57,792	3,769,581	567,740	215,122	30.00
ANCILLARY SERVICE COST CENTERS						
50.00	29,807	160,410	2,516,986	379,086	143,602	50.00
51.00	301	44,214	286,616	43,168	15,338	51.00
53.00	3,251	9,999	73,535	11,075	1,511	53.00
54.00	3,285	249,632	2,410,846	363,100	76,807	54.00
60.00	5,273	288,361	2,780,209	418,730	48,629	60.00
64.00	15,884	22,737	1,041,536	156,867	21,574	64.00
65.00	879	32,599	653,175	98,375	13,014	65.00
65.01	824	100,692	2,229,995	335,862	82,927	65.01
65.02	0	7,498	501,934	75,597	23,801	65.02
66.00	579	23,079	581,534	87,585	0	66.00
71.00	0	58,740	657,635	99,047	0	71.00
72.00	0	7,758	191,937	28,908	0	72.00
73.00	0	156,281	171,593	25,844	0	73.00
76.97	271	8,969	431,399	64,973	34,337	76.97
OUTPATIENT SERVICE COST CENTERS						
91.00	8,973	88,670	1,954,714	294,401	79,557	91.00
92.00			0			92.00
SPECIAL PURPOSE COST CENTERS						
113.00						113.00
118.00	84,165	1,317,431	33,806,008	4,423,064	1,148,195	118.00
NONREIMBURSABLE COST CENTERS						
190.00	0	0	15,896	2,394	8,347	190.00
192.00	0	0	40,407	6,086	17,217	192.00
192.01	0	0	46,801	7,049	24,576	192.01
200.00			0			200.00
201.00	0	0	0	0	0	201.00
202.00	84,165	1,317,431	33,909,112	4,438,593	1,198,335	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141334

Period:
From 04/01/2011
To 03/31/2012

Worksheet B
Part I
Date/Time Prepared:
8/21/2012 10:22 am

Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.01	DATA PROCESSING						5.01
5.02	PURCHASING RECEIVING AND STORES						5.02
5.03	CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04	OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00	MAINTENANCE & REPAIRS						6.00
7.00	OPERATION OF PLANT	454,513					7.00
8.00	LAUNDRY & LINEN SERVICE	6,351	144,381				8.00
9.00	HOUSEKEEPING	1,139	443	449,554			9.00
10.00	DIETARY	24,835	431	1,360	409,310		10.00
11.00	CAFETERIA	17,048	0	7,343	0	511,665	11.00
13.00	NURSING ADMINISTRATION	19,839	0	544	0	25,583	13.00
14.00	CENTRAL SERVICES & SUPPLY	4,940	0	0	0	0	14.00
15.00	PHARMACY	7,738	0	5,983	0	12,792	15.00
16.00	MEDICAL RECORDS & LIBRARY	34,955	0	0	0	6,396	16.00
17.00	SOCIAL SERVICE	3,785	0	544	0	3,198	17.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	89,073	56,254	219,203	409,310	115,124	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	59,460	21,583	58,744	0	60,760	50.00
51.00	RECOVERY ROOM	6,351	7,430	4,895	0	6,396	51.00
53.00	ANESTHESIOLOGY	625	0	1,632	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	31,803	11,551	18,221	0	38,375	54.00
60.00	LABORATORY	20,136	0	15,502	0	35,177	60.00
64.00	INTRAVENOUS THERAPY	8,933	0	21,757	0	28,781	64.00
65.00	RESPIRATORY THERAPY	5,389	179	4,351	0	22,385	65.00
65.01	SLEEP DISORDERS	34,337	11,671	40,250	0	70,354	65.01
65.02	GERIATRIC PSYCH	9,855	0	4,623	0	0	65.02
66.00	PHYSICAL THERAPY	0	0	0	0	15,990	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	CARDIAC REHABILITATION	14,218	461	7,071	0	15,990	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	EMERGENCY	32,942	34,378	37,531	0	54,364	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	433,752	144,381	449,554	409,310	511,665	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,456	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	7,129	0	0	0	0	192.00
192.01	UNUSED SPACE	10,176	0	0	0	0	192.01
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	454,513	144,381	449,554	409,310	511,665	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141334

Period:
From 04/01/2011
To 03/31/2012

Worksheet B
Part I
Date/Time Prepared:
8/21/2012 10:22 am

Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
	13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS						
1.00 CAP REL COSTS-BLDG & FIXT						1.00
2.00 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 EMPLOYEE BENEFITS						4.00
5.01 DATA PROCESSING						5.01
5.02 PURCHASING RECEIVING AND STORES						5.02
5.03 CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04 OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00 MAINTENANCE & REPAIRS						6.00
7.00 OPERATION OF PLANT						7.00
8.00 LAUNDRY & LINEN SERVICE						8.00
9.00 HOUSEKEEPING						9.00
10.00 DIETARY						10.00
11.00 CAFETERIA						11.00
13.00 NURSING ADMINISTRATION	1,605,124					13.00
14.00 CENTRAL SERVICES & SUPPLY	0	71,556				14.00
15.00 PHARMACY	82,193	13	5,802,287			15.00
16.00 MEDICAL RECORDS & LIBRARY	0	0	0	414,732		16.00
17.00 SOCIAL SERVICE	0	0	0	0	84,868	17.00
19.00 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	742,696	453	10,105	94,798	84,868	30.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	387,182	62,474	4,818	67,451	0	50.00
51.00 RECOVERY ROOM	47,406	0	234	0	0	51.00
53.00 ANESTHESIOLOGY	0	674	418	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	42	36,460	0	54.00
60.00 LABORATORY	0	8	0	37,371	0	60.00
64.00 INTRAVENOUS THERAPY	0	5,064	1,392	33,725	0	64.00
65.00 RESPIRATORY THERAPY	0	2,747	0	8,203	0	65.00
65.01 SLEEP DISORDERS	0	0	0	51,955	0	65.01
65.02 GERIATRIC PSYCH	0	0	0	1,823	0	65.02
66.00 PHYSICAL THERAPY	0	39	0	10,026	0	66.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	5,782,786	0	0	73.00
76.97 CARDIAC REHABILITATION	0	26	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
91.00 EMERGENCY	345,647	58	2,492	72,920	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS						
113.00 INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	1,605,124	71,556	5,802,287	414,732	84,868	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
192.01 UNUSED SPACE	0	0	0	0	0	192.01
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	1,605,124	71,556	5,802,287	414,732	84,868	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141334

Period:
From 04/01/2011
To 03/31/2012

Worksheet B
Part I
Date/Time Prepared:
8/21/2012 10:22 am

Cost Center Description	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	19.00	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
4.00 EMPLOYEE BENEFITS					4.00
5.01 DATA PROCESSING					5.01
5.02 PURCHASING RECEIVING AND STORES					5.02
5.03 CASHIERING/ACCOUNTS RECEIVABLE					5.03
5.04 OTHER ADMINISTRATIVE AND GENERAL					5.04
6.00 MAINTENANCE & REPAIRS					6.00
7.00 OPERATION OF PLANT					7.00
8.00 LAUNDRY & LINEN SERVICE					8.00
9.00 HOUSEKEEPING					9.00
10.00 DIETARY					10.00
11.00 CAFETERIA					11.00
13.00 NURSING ADMINISTRATION					13.00
14.00 CENTRAL SERVICES & SUPPLY					14.00
15.00 PHARMACY					15.00
16.00 MEDICAL RECORDS & LIBRARY					16.00
17.00 SOCIAL SERVICE					17.00
19.00 NONPHYSICIAN ANESTHETISTS	0				19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 ADULTS & PEDIATRICS	0	6,374,327	0	6,374,327	30.00
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	0	3,762,146	0	3,762,146	50.00
51.00 RECOVERY ROOM	0	417,834	0	417,834	51.00
53.00 ANESTHESIOLOGY	0	89,470	0	89,470	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	2,987,205	0	2,987,205	54.00
60.00 LABORATORY	0	3,355,762	0	3,355,762	60.00
64.00 INTRAVENOUS THERAPY	0	1,319,629	0	1,319,629	64.00
65.00 RESPIRATORY THERAPY	0	807,818	0	807,818	65.00
65.01 SLEEP DISORDERS	0	2,857,351	0	2,857,351	65.01
65.02 GERIATRIC PSYCH	0	617,633	0	617,633	65.02
66.00 PHYSICAL THERAPY	0	695,174	0	695,174	66.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	756,682	0	756,682	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	220,845	0	220,845	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	5,980,223	0	5,980,223	73.00
76.97 CARDIAC REHABILITATION	0	568,475	0	568,475	76.97
OUTPATIENT SERVICE COST CENTERS					
91.00 EMERGENCY	0	2,909,004	0	2,909,004	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)			0		92.00
SPECIAL PURPOSE COST CENTERS					
113.00 INTEREST EXPENSE					113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	33,719,578	0	33,719,578	118.00
NONREIMBURSABLE COST CENTERS					
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	30,093	0	30,093	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	70,839	0	70,839	192.00
192.01 UNUSED SPACE	0	88,602	0	88,602	192.01
200.00 Cross Foot Adjustments	0	0	0	0	200.00
201.00 Negative Cost Centers	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	0	33,909,112	0	33,909,112	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141334

Period:
From 04/01/2011
To 03/31/2012

Worksheet B
Part II
Date/Time Prepared:
8/21/2012 10:22 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	EMPLOYEE BENEFITS	0	5,158	7,419	12,577	4.00
5.01	DATA PROCESSING	0	4,326	6,222	10,548	5.01
5.02	PURCHASING RECEIVING AND STORES	0	4,311	6,200	10,511	5.02
5.03	CASHIERING/ACCOUNTS RECEIVABLE	0	14,732	21,190	35,922	5.03
5.04	OTHER ADMINISTRATIVE AND GENERAL	0	303,641	436,739	740,380	5.04
6.00	MAINTENANCE & REPAIRS	0	41,534	59,740	101,274	6.00
7.00	OPERATION OF PLANT	0	78,606	113,062	191,668	7.00
8.00	LAUNDRY & LINEN SERVICE	0	11,979	17,230	29,209	8.00
9.00	HOUSEKEEPING	0	2,148	3,089	5,237	9.00
10.00	DIETARY	0	46,843	67,376	114,219	10.00
11.00	CAFETERIA	0	32,156	46,252	78,408	11.00
13.00	NURSING ADMINISTRATION	0	37,420	53,823	91,243	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	9,317	13,401	22,718	14.00
15.00	PHARMACY	0	14,596	20,994	35,590	15.00
16.00	MEDICAL RECORDS & LIBRARY	0	65,931	94,831	160,762	16.00
17.00	SOCIAL SERVICE	0	7,139	10,268	17,407	17.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	0	168,012	241,658	409,670	30.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	112,154	161,315	273,469	50.00
51.00	RECOVERY ROOM	0	11,979	17,230	29,209	51.00
53.00	ANESTHESIOLOGY	0	1,180	1,697	2,877	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	59,987	86,281	146,268	54.00
60.00	LABORATORY	0	37,980	54,628	92,608	60.00
64.00	INTRAVENOUS THERAPY	0	16,850	24,235	41,085	64.00
65.00	RESPIRATORY THERAPY	0	10,164	14,620	24,784	65.00
65.01	SLEEP DISORDERS	0	64,767	93,156	157,923	65.01
65.02	GERIATRIC PSYCH	0	18,589	26,737	45,326	65.02
66.00	PHYSICAL THERAPY	0	0	0	0	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.97	CARDIAC REHABILITATION	0	26,817	38,572	65,389	76.97
OUTPATIENT SERVICE COST CENTERS						
91.00	EMERGENCY	0	62,135	89,371	151,506	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)				0	92.00
SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	1,270,451	1,827,336	3,097,787	118.00
NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6,519	9,377	15,896	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	13,446	19,340	32,786	192.00
192.01	UNUSED SPACE	0	19,194	27,607	46,801	192.01
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	1,309,610	1,883,660	3,193,270	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141334

Period:
From 04/01/2011
To 03/31/2012

Worksheet B
Part II
Date/Time Prepared:
8/21/2012 10:22 am

Cost Center Description	DATA PROCESSING	PURCHASING RECEIVING AND STORES	CASHIERING/ACCOUNTS RECEIVABLE	OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	
	5.01	5.02	5.03	5.04	6.00	
GENERAL SERVICE COST CENTERS						
1.00						1.00
2.00						2.00
4.00						4.00
5.01	10,548					5.01
5.02	84	10,624				5.02
5.03	506	123	36,997			5.03
5.04	802	0	0	741,961		5.04
6.00	42	0	0	26,220	127,865	6.00
7.00	0	0	0	7,743	10,739	7.00
8.00	0	0	0	2,685	1,637	8.00
9.00	127	0	0	9,742	293	9.00
10.00	127	4	0	7,061	6,400	10.00
11.00	0	11	0	9,761	4,393	11.00
13.00	1,224	0	0	33,067	5,112	13.00
14.00	0	21	0	1,197	1,273	14.00
15.00	211	0	0	124,179	1,994	15.00
16.00	295	0	0	6,323	9,008	16.00
17.00	42	0	0	1,492	975	17.00
19.00	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	1,392	1,712	1,623	94,903	22,954	30.00
ANCILLARY SERVICE COST CENTERS						
50.00	802	3,764	4,506	63,368	15,323	50.00
51.00	84	38	1,242	7,216	1,637	51.00
53.00	127	410	281	1,851	161	53.00
54.00	802	415	7,012	60,695	8,195	54.00
60.00	759	666	8,089	69,995	5,189	60.00
64.00	464	2,005	639	26,222	2,302	64.00
65.00	338	111	916	16,444	1,389	65.00
65.01	759	104	2,829	56,142	8,848	65.01
65.02	211	0	211	12,637	2,540	65.02
66.00	422	73	648	14,641	0	66.00
71.00	0	0	1,650	16,557	0	71.00
72.00	0	0	218	4,832	0	72.00
73.00	0	0	4,390	4,320	0	73.00
76.97	169	34	252	10,861	3,664	76.97
OUTPATIENT SERVICE COST CENTERS						
91.00	759	1,133	2,491	49,212	8,489	91.00
92.00						92.00
SPECIAL PURPOSE COST CENTERS						
113.00						113.00
118.00	10,548	10,624	36,997	739,366	122,515	118.00
NONREIMBURSABLE COST CENTERS						
190.00	0	0	0	400	891	190.00
192.00	0	0	0	1,017	1,837	192.00
192.01	0	0	0	1,178	2,622	192.01
200.00						200.00
201.00	0	0	0	0	0	201.00
202.00	10,548	10,624	36,997	741,961	127,865	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 141334			Period: From 04/01/2011 To 03/31/2012		Worksheet B Part II Date/Time Prepared: 8/21/2012 10:22 am	
Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA		
		7.00	8.00	9.00	10.00	11.00		
GENERAL SERVICE COST CENTERS								
1.00	CAP REL COSTS-BLDG & FIXT							1.00
2.00	CAP REL COSTS-MVBLE EQUIP							2.00
4.00	EMPLOYEE BENEFITS							4.00
5.01	DATA PROCESSING							5.01
5.02	PURCHASING RECEIVING AND STORES							5.02
5.03	CASHIERING/ACCOUNTS RECEIVABLE							5.03
5.04	OTHER ADMINISTRATIVE AND GENERAL							5.04
6.00	MAINTENANCE & REPAIRS							6.00
7.00	OPERATION OF PLANT	210,242						7.00
8.00	LAUNDRY & LINEN SERVICE	2,938	36,469					8.00
9.00	HOUSEKEEPING	527	112	16,294				9.00
10.00	DIETARY	11,488	109	49	139,555			10.00
11.00	CAFETERIA	7,886	0	266	0	100,977		11.00
13.00	NURSING ADMINISTRATION	9,177	0	20	0	5,049		13.00
14.00	CENTRAL SERVICES & SUPPLY	2,285	0	0	0	0		14.00
15.00	PHARMACY	3,579	0	217	0	2,524		15.00
16.00	MEDICAL RECORDS & LIBRARY	16,169	0	0	0	1,262		16.00
17.00	SOCIAL SERVICE	1,751	0	20	0	631		17.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0		19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	41,200	14,208	7,945	139,555	22,720		30.00
ANCILLARY SERVICE COST CENTERS								
50.00	OPERATING ROOM	27,504	5,452	2,129	0	11,991		50.00
51.00	RECOVERY ROOM	2,938	1,877	177	0	1,262		51.00
53.00	ANESTHESIOLOGY	289	0	59	0	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	14,711	2,918	660	0	7,573		54.00
60.00	LABORATORY	9,314	0	562	0	6,942		60.00
64.00	INTRAVENOUS THERAPY	4,132	0	789	0	5,680		64.00
65.00	RESPIRATORY THERAPY	2,493	45	158	0	4,418		65.00
65.01	SLEEP DISORDERS	15,883	2,948	1,459	0	13,884		65.01
65.02	GERIATRIC PSYCH	4,559	0	168	0	0		65.02
66.00	PHYSICAL THERAPY	0	0	0	0	3,156		66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0		73.00
76.97	CARDIAC REHABILITATION	6,577	116	256	0	3,156		76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	EMERGENCY	15,238	8,684	1,360	0	10,729		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)							92.00
SPECIAL PURPOSE COST CENTERS								
113.00	INTEREST EXPENSE							113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	200,638	36,469	16,294	139,555	100,977		118.00
NONREIMBURSABLE COST CENTERS								
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,599	0	0	0	0		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	3,298	0	0	0	0		192.00
192.01	UNUSED SPACE	4,707	0	0	0	0		192.01
200.00	Cross Foot Adjustments							200.00
201.00	Negative Cost Centers	0	0	0	0	0		201.00
202.00	TOTAL (sum lines 118-201)	210,242	36,469	16,294	139,555	100,977		202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141334

Period:
From 04/01/2011
To 03/31/2012

Worksheet B
Part II
Date/Time Prepared:
8/21/2012 10:22 am

Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
	13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS						
1.00 CAP REL COSTS-BLDG & FIXT						1.00
2.00 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 EMPLOYEE BENEFITS						4.00
5.01 DATA PROCESSING						5.01
5.02 PURCHASING RECEIVING AND STORES						5.02
5.03 CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04 OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00 MAINTENANCE & REPAIRS						6.00
7.00 OPERATION OF PLANT						7.00
8.00 LAUNDRY & LINEN SERVICE						8.00
9.00 HOUSEKEEPING						9.00
10.00 DIETARY						10.00
11.00 CAFETERIA						11.00
13.00 NURSING ADMINISTRATION	145,696					13.00
14.00 CENTRAL SERVICES & SUPPLY	0	27,494				14.00
15.00 PHARMACY	7,461	5	176,100			15.00
16.00 MEDICAL RECORDS & LIBRARY	0	0	0	193,879		16.00
17.00 SOCIAL SERVICE	0	0	0	0	22,348	17.00
19.00 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	67,414	174	307	44,316	22,348	30.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	35,144	24,005	146	31,532	0	50.00
51.00 RECOVERY ROOM	4,303	0	7	0	0	51.00
53.00 ANESTHESIOLOGY	0	259	13	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	1	17,044	0	54.00
60.00 LABORATORY	0	3	0	17,470	0	60.00
64.00 INTRAVENOUS THERAPY	0	1,946	42	15,766	0	64.00
65.00 RESPIRATORY THERAPY	0	1,055	0	3,835	0	65.00
65.01 SLEEP DISORDERS	0	0	0	24,288	0	65.01
65.02 GERIATRIC PSYCH	0	0	0	852	0	65.02
66.00 PHYSICAL THERAPY	0	15	0	4,687	0	66.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	175,508	0	0	73.00
76.97 CARDIAC REHABILITATION	0	10	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
91.00 EMERGENCY	31,374	22	76	34,089	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS						
113.00 INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	145,696	27,494	176,100	193,879	22,348	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
192.01 UNUSED SPACE	0	0	0	0	0	192.01
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	145,696	27,494	176,100	193,879	22,348	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141334

Period:
From 04/01/2011
To 03/31/2012

Worksheet B
Part II
Date/Time Prepared:
8/21/2012 10:22 am

Cost Center Description		NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		19.00	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
4.00	EMPLOYEE BENEFITS					4.00
5.01	DATA PROCESSING					5.01
5.02	PURCHASING RECEIVING AND STORES					5.02
5.03	CASHIERING/ACCOUNTS RECEIVABLE					5.03
5.04	OTHER ADMINISTRATIVE AND GENERAL					5.04
6.00	MAINTENANCE & REPAIRS					6.00
7.00	OPERATION OF PLANT					7.00
8.00	LAUNDRY & LINEN SERVICE					8.00
9.00	HOUSEKEEPING					9.00
10.00	DIETARY					10.00
11.00	CAFETERIA					11.00
13.00	NURSING ADMINISTRATION					13.00
14.00	CENTRAL SERVICES & SUPPLY					14.00
15.00	PHARMACY					15.00
16.00	MEDICAL RECORDS & LIBRARY					16.00
17.00	SOCIAL SERVICE					17.00
19.00	NONPHYSICIAN ANESTHETISTS	0				19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS		894,695	0	894,695	30.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM		500,299	0	500,299	50.00
51.00	RECOVERY ROOM		50,150	0	50,150	51.00
53.00	ANESTHESIOLOGY		6,327	0	6,327	53.00
54.00	RADIOLOGY-DIAGNOSTIC		267,191	0	267,191	54.00
60.00	LABORATORY		212,341	0	212,341	60.00
64.00	INTRAVENOUS THERAPY		101,597	0	101,597	64.00
65.00	RESPIRATORY THERAPY		56,398	0	56,398	65.00
65.01	SLEEP DISORDERS		286,293	0	286,293	65.01
65.02	GERIATRIC PSYCH		66,504	0	66,504	65.02
66.00	PHYSICAL THERAPY		23,951	0	23,951	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS		18,207	0	18,207	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS		5,050	0	5,050	72.00
73.00	DRUGS CHARGED TO PATIENTS		184,218	0	184,218	73.00
76.97	CARDIAC REHABILITATION		90,768	0	90,768	76.97
OUTPATIENT SERVICE COST CENTERS						
91.00	EMERGENCY		316,249	0	316,249	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)			0		92.00
SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	3,080,238	0	3,080,238	118.00
NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN		18,786	0	18,786	190.00
192.00	PHYSICIANS' PRIVATE OFFICES		38,938	0	38,938	192.00
192.01	UNUSED SPACE		55,308	0	55,308	192.01
200.00	Cross Foot Adjustments	0	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	3,193,270	0	3,193,270	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141334

Period:
From 04/01/2011
To 03/31/2012

Worksheet B-1
Date/Time Prepared:
8/21/2012 10:22 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	DATA PROCESSING (# OF PCS)	PURCHASING RECEIVING AND STORES (PURCHASED SUPPLIES)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 CAP REL COSTS-BLDG & FIXT	86,584					1.00
2.00 CAP REL COSTS-MVBLE EQUIP		86,584				2.00
4.00 EMPLOYEE BENEFITS	341	341	12,018,957			4.00
5.01 DATA PROCESSING	286	286	0	250		5.01
5.02 PURCHASING RECEIVING AND STORES	285	285	28,049	2	910,740	5.02
5.03 CASHIERING/ACCOUNTS RECEIVABLE	974	974	426,353	12	10,575	5.03
5.04 OTHER ADMINISTRATIVE AND GENERAL	20,075	20,075	744,414	19	0	5.04
6.00 MAINTENANCE & REPAIRS	2,746	2,746	314,124	1	0	6.00
7.00 OPERATION OF PLANT	5,197	5,197	87,681	0	0	7.00
8.00 LAUNDRY & LINEN SERVICE	792	792	0	0	0	8.00
9.00 HOUSEKEEPING	142	142	245,138	3	28	9.00
10.00 DIETARY	3,097	3,097	93,889	3,097	382	10.00
11.00 CAFETERIA	2,126	2,126	241,131	0	980	11.00
13.00 NURSING ADMINISTRATION	2,474	2,474	769,025	29	32	13.00
14.00 CENTRAL SERVICES & SUPPLY	616	616	393	0	1,769	14.00
15.00 PHARMACY	965	965	325,393	5	0	15.00
16.00 MEDICAL RECORDS & LIBRARY	4,359	4,359	57,128	7	0	16.00
17.00 SOCIAL SERVICE	472	472	28,451	1	0	17.00
19.00 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	11,108	11,108	2,149,174	33	146,792	30.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	7,415	7,415	1,112,969	19	322,542	50.00
51.00 RECOVERY ROOM	792	792	152,543	2	3,257	51.00
53.00 ANESTHESIOLOGY	78	78	0	3	35,176	53.00
54.00 RADIOLOGY-DIAGNOSTIC	3,966	3,966	857,346	19	35,551	54.00
60.00 LABORATORY	2,511	2,511	711,184	18	57,060	60.00
64.00 INTRAVENOUS THERAPY	1,114	1,114	502,352	11	171,884	64.00
65.00 RESPIRATORY THERAPY	672	672	393,589	8	9,507	65.00
65.01 SLEEP DISORDERS	4,282	4,282	1,172,384	18	8,916	65.01
65.02 GERIATRIC PSYCH	1,229	1,229	0	5	0	65.02
66.00 PHYSICAL THERAPY	0	0	295,254	10	6,261	66.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97 CARDIAC REHABILITATION	1,773	1,773	271,430	4	2,931	76.97
OUTPATIENT SERVICE COST CENTERS						
91.00 EMERGENCY	4,108	4,108	1,039,563	18	97,097	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS						
113.00 INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	83,995	83,995	12,018,957	250	910,740	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	431	431	0	0	0	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	889	889	0	0	0	192.00
192.01 UNUSED SPACE	1,269	1,269	0	0	0	192.01
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	1,309,610	1,883,660	3,716,550	1,058,513	84,165	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	15.125312	21.755290	0.309224	4,234.052000	0.092414	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)			12,577	10,548	10,624	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)			0.001046	42.192000	0.011665	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141334

Period:
From 04/01/2011
To 03/31/2012

Worksheet B-1

Date/Time Prepared:
8/21/2012 10:22 am

Cost Center Description		CASHIERING/ACCOUNTS RECEIVABLE (GROSS REVENUE)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	
		5.03	5A.04	5.04	6.00	7.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.01	DATA PROCESSING						5.01
5.02	PURCHASING RECEIVING AND STORES						5.02
5.03	CASHIERING/ACCOUNTS RECEIVABLE	110,797,910					5.03
5.04	OTHER ADMINISTRATIVE AND GENERAL	0	-4,438,593	29,470,519			5.04
6.00	MAINTENANCE & REPAIRS	0	0	1,041,477	61,877		6.00
7.00	OPERATION OF PLANT	0	0	307,546	5,197	56,680	7.00
8.00	LAUNDRY & LINEN SERVICE	0	0	106,632	792	792	8.00
9.00	HOUSEKEEPING	0	0	386,944	142	142	9.00
10.00	DIETARY	0	0	280,465	3,097	3,097	10.00
11.00	CAFETERIA	0	0	387,708	2,126	2,126	11.00
13.00	NURSING ADMINISTRATION	0	0	1,313,429	2,474	2,474	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	47,528	616	616	14.00
15.00	PHARMACY	0	0	4,932,049	965	965	15.00
16.00	MEDICAL RECORDS & LIBRARY	0	0	251,139	4,359	4,359	16.00
17.00	SOCIAL SERVICE	0	0	59,273	472	472	17.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	4,860,597	0	3,769,581	11,108	11,108	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	13,491,158	0	2,516,986	7,415	7,415	50.00
51.00	RECOVERY ROOM	3,718,558	0	286,616	792	792	51.00
53.00	ANESTHESIOLOGY	840,977	0	73,535	78	78	53.00
54.00	RADIOLOGY-DIAGNOSTIC	20,995,147	0	2,410,846	3,966	3,966	54.00
60.00	LABORATORY	24,248,729	0	2,780,209	2,511	2,511	60.00
64.00	INTRAVENOUS THERAPY	1,912,251	0	1,041,536	1,114	1,114	64.00
65.00	RESPIRATORY THERAPY	2,741,723	0	653,175	672	672	65.00
65.01	SLEEP DISORDERS	8,468,592	0	2,229,995	4,282	4,282	65.01
65.02	GERIATRIC PSYCH	630,576	0	501,934	1,229	1,229	65.02
66.00	PHYSICAL THERAPY	1,941,025	0	581,534	0	0	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,940,323	0	657,635	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	652,512	0	191,937	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	13,143,932	0	171,593	0	0	73.00
76.97	CARDIAC REHABILITATION	754,324	0	431,399	1,773	1,773	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	EMERGENCY	7,457,486	0	1,954,714	4,108	4,108	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	110,797,910	-4,438,593	29,367,415	59,288	54,091	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	15,896	431	431	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	40,407	889	889	192.00
192.01	UNUSED SPACE	0	0	46,801	1,269	1,269	192.01
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	1,317,431		4,438,593	1,198,335	454,513	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.011890		0.150611	19.366404	8.018931	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	36,997		741,961	127,865	210,242	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000334		0.025176	2.066438	3.709280	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141334

Period:
From 04/01/2011
To 03/31/2012

Worksheet B-1
Date/Time Prepared:
8/21/2012 10:22 am

Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (# OF FTES)	NURSING ADMINISTRATION (DIRECT NURSING HOURS)	
	8.00	9.00	10.00	11.00	13.00	
GENERAL SERVICE COST CENTERS						
1.00 CAP REL COSTS-BLDG & FIXT						1.00
2.00 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 EMPLOYEE BENEFITS						4.00
5.01 DATA PROCESSING						5.01
5.02 PURCHASING RECEIVING AND STORES						5.02
5.03 CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04 OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00 MAINTENANCE & REPAIRS						6.00
7.00 OPERATION OF PLANT						7.00
8.00 LAUNDRY & LINEN SERVICE	24,136					8.00
9.00 HOUSEKEEPING	74	1,653				9.00
10.00 DIETARY	72	5	18,509			10.00
11.00 CAFETERIA	0	27	0	160		11.00
13.00 NURSING ADMINISTRATION	0	2	0	8	161,034	13.00
14.00 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00 PHARMACY	0	22	0	4	8,246	15.00
16.00 MEDICAL RECORDS & LIBRARY	0	0	0	2	0	16.00
17.00 SOCIAL SERVICE	0	2	0	1	0	17.00
19.00 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	9,404	806	18,509	36	74,511	30.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	3,608	216	0	19	38,844	50.00
51.00 RECOVERY ROOM	1,242	18	0	2	4,756	51.00
53.00 ANESTHESIOLOGY	0	6	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	1,931	67	0	12	0	54.00
60.00 LABORATORY	0	57	0	11	0	60.00
64.00 INTRAVENOUS THERAPY	0	80	0	9	0	64.00
65.00 RESPIRATORY THERAPY	30	16	0	7	0	65.00
65.01 SLEEP DISORDERS	1,951	148	0	22	0	65.01
65.02 GERIATRIC PSYCH	0	17	0	0	0	65.02
66.00 PHYSICAL THERAPY	0	0	0	5	0	66.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97 CARDIAC REHABILITATION	77	26	0	5	0	76.97
OUTPATIENT SERVICE COST CENTERS						
91.00 EMERGENCY	5,747	138	0	17	34,677	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS						
113.00 INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	24,136	1,653	18,509	160	161,034	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
192.01 UNUSED SPACE	0	0	0	0	0	192.01
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	144,381	449,554	409,310	511,665	1,605,124	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	5.981977	271.962492	22.114107	3,197.906250	9.967609	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	36,469	16,294	139,555	100,977	145,696	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)	1.510979	9.857229	7.539845	631.106250	0.904753	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141334

Period:
From 04/01/2011
To 03/31/2012

Worksheet B-1

Date/Time Prepared:
8/21/2012 10:22 am

Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (PATIENT DAYS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
	14.00	15.00	16.00	17.00	19.00	
GENERAL SERVICE COST CENTERS						
1.00 CAP REL COSTS-BLDG & FIXT						1.00
2.00 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 EMPLOYEE BENEFITS						4.00
5.01 DATA PROCESSING						5.01
5.02 PURCHASING RECEIVING AND STORES						5.02
5.03 CASHIERING/ACCOUNTS RECEIVABLE						5.03
5.04 OTHER ADMINISTRATIVE AND GENERAL						5.04
6.00 MAINTENANCE & REPAIRS						6.00
7.00 OPERATION OF PLANT						7.00
8.00 LAUNDRY & LINEN SERVICE						8.00
9.00 HOUSEKEEPING						9.00
10.00 DIETARY						10.00
11.00 CAFETERIA						11.00
13.00 NURSING ADMINISTRATION						13.00
14.00 CENTRAL SERVICES & SUPPLY	842,876					14.00
15.00 PHARMACY	157	4,314,088				15.00
16.00 MEDICAL RECORDS & LIBRARY	0	0	455			16.00
17.00 SOCIAL SERVICE	0	0	0	2,998		17.00
19.00 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	5,340	7,513	104	2,998		30.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	735,905	3,582	74	0	0	50.00
51.00 RECOVERY ROOM	0	174	0	0	0	51.00
53.00 ANESTHESIOLOGY	7,937	311	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	31	40	0	0	54.00
60.00 LABORATORY	89	0	41	0	0	60.00
64.00 INTRAVENOUS THERAPY	59,645	1,035	37	0	0	64.00
65.00 RESPIRATORY THERAPY	32,354	0	9	0	0	65.00
65.01 SLEEP DISORDERS	0	0	57	0	0	65.01
65.02 GERIATRIC PSYCH	0	0	2	0	0	65.02
66.00 PHYSICAL THERAPY	465	0	11	0	0	66.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	4,299,589	0	0	0	73.00
76.97 CARDIAC REHABILITATION	305	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
91.00 EMERGENCY	679	1,853	80	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS						
113.00 INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	842,876	4,314,088	455	2,998	0	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
192.01 UNUSED SPACE	0	0	0	0	0	192.01
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	71,556	5,802,287	414,732	84,868	0	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	0.084895	1.344963	911.498901	28.308205	0.000000	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	27,494	176,100	193,879	22,348	0	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)	0.032619	0.040820	426.107692	7.454303	0.000000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 141334	Period: From 04/01/2011 To 03/31/2012	Worksheet C Part I Date/Time Prepared: 8/21/2012 10:22 am
		Title XVIII	Hospital	Cost

Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE Disallowance	Total Costs		
	1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	6,374,327		6,374,327	0	0	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	3,762,146		3,762,146	0	0	50.00
51.00	RECOVERY ROOM	417,834		417,834	0	0	51.00
53.00	ANESTHESIOLOGY	89,470		89,470	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	2,987,205		2,987,205	0	0	54.00
60.00	LABORATORY	3,355,762		3,355,762	0	0	60.00
64.00	INTRAVENOUS THERAPY	1,319,629		1,319,629	0	0	64.00
65.00	RESPIRATORY THERAPY	807,818	0	807,818	0	0	65.00
65.01	SLEEP DISORDERS	2,857,351	0	2,857,351	0	0	65.01
65.02	GERIATRIC PSYCH	617,633	0	617,633	0	0	65.02
66.00	PHYSICAL THERAPY	695,174	0	695,174	0	0	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	756,682		756,682	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	220,845		220,845	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	5,980,223		5,980,223	0	0	73.00
76.97	CARDIAC REHABILITATION	568,475		568,475	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	EMERGENCY	2,909,004		2,909,004	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1,561,879		1,561,879	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	35,281,457	0	35,281,457	0	0	200.00
201.00	Less Observation Beds	1,561,879		1,561,879		0	201.00
202.00	Total (see instructions)	33,719,578	0	33,719,578	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141334

Period:
From 04/01/2011
To 03/31/2012

Worksheet C
Part I
Date/Time Prepared:
8/21/2012 10:22 am

			Title XVIII	Hospital	Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	3,364,897		3,364,897		30.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	585,199	12,522,773	13,107,972	0.287012	50.00
51.00	RECOVERY ROOM	141,618	3,473,276	3,614,894	0.115587	51.00
53.00	ANESTHESIOLOGY	80,298	752,611	832,909	0.107419	53.00
54.00	RADIOLOGY-DIAGNOSTIC	1,438,901	19,288,063	20,726,964	0.144122	54.00
60.00	LABORATORY	1,912,190	21,885,301	23,797,491	0.141013	60.00
64.00	INTRAVENOUS THERAPY	29,508	1,882,743	1,912,251	0.690092	64.00
65.00	RESPIRATORY THERAPY	910,189	1,590,818	2,501,007	0.322997	65.00
65.01	SLEEP DISORDERS	179	8,250,513	8,250,692	0.346317	65.01
65.02	GERIATRIC PSYCH	0	630,576	630,576	0.979474	65.02
66.00	PHYSICAL THERAPY	106,820	1,801,856	1,908,676	0.364218	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	666,975	4,211,239	4,878,214	0.155115	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	91,079	553,785	644,864	0.342468	72.00
73.00	DRUGS CHARGED TO PATIENTS	2,346,182	10,561,150	12,907,332	0.463320	73.00
76.97	CARDIAC REHABILITATION	0	751,516	751,516	0.756438	76.97
OUTPATIENT SERVICE COST CENTERS						
91.00	EMERGENCY	432,676	6,966,731	7,399,407	0.393140	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	75,562	1,402,497	1,478,059	1.056710	92.00
SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)	12,182,273	96,525,448	108,707,721		200.00
201.00	Less Observation Beds					201.00
202.00	Total (see instructions)	12,182,273	96,525,448	108,707,721		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 141334	Period: From 04/01/2011 To 03/31/2012	Worksheet C Part I Date/Time Prepared: 8/21/2012 10:22 am
		Title XVIII	Hospital	Cost
Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS			30.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0.000000		50.00
51.00	RECOVERY ROOM	0.000000		51.00
53.00	ANESTHESIOLOGY	0.000000		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	LABORATORY	0.000000		60.00
64.00	INTRAVENOUS THERAPY	0.000000		64.00
65.00	RESPIRATORY THERAPY	0.000000		65.00
65.01	SLEEP DISORDERS	0.000000		65.01
65.02	GERIATRIC PSYCH	0.000000		65.02
66.00	PHYSICAL THERAPY	0.000000		66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.97	CARDIAC REHABILITATION	0.000000		76.97
OUTPATIENT SERVICE COST CENTERS				
91.00	EMERGENCY	0.000000		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
SPECIAL PURPOSE COST CENTERS				
113.00	INTEREST EXPENSE			113.00
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: 141334	Period: From 04/01/2011 To 03/31/2012	Worksheet C Part I Date/Time Prepared: 8/21/2012 10:22 am
		Title XIX	Hospital	Cost

Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS		6,374,327	0	0	30.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM		3,762,146	0	0	50.00
51.00	RECOVERY ROOM		417,834	0	0	51.00
53.00	ANESTHESIOLOGY		89,470	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC		2,987,205	0	0	54.00
60.00	LABORATORY		3,355,762	0	0	60.00
64.00	INTRAVENOUS THERAPY		1,319,629	0	0	64.00
65.00	RESPIRATORY THERAPY	0	807,818	0	0	65.00
65.01	SLEEP DISORDERS	0	2,857,351	0	0	65.01
65.02	GERIATRIC PSYCH	0	617,633	0	0	65.02
66.00	PHYSICAL THERAPY	0	695,174	0	0	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS		756,682	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS		220,845	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS		5,980,223	0	0	73.00
76.97	CARDIAC REHABILITATION		568,475	0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
91.00	EMERGENCY		2,909,004	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)		1,561,879	0	0	92.00
SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)	0	35,281,457	0	0	200.00
201.00	Less Observation Beds		1,561,879		0	201.00
202.00	Total (see instructions)	0	33,719,578	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141334

Period:
From 04/01/2011
To 03/31/2012

Worksheet C
Part I
Date/Time Prepared:
8/21/2012 10:22 am

		Title XIX			Hospital	Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	3,364,897		3,364,897			30.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	585,199	12,522,773	13,107,972	0.287012	0.000000	50.00
51.00	RECOVERY ROOM	141,618	3,473,276	3,614,894	0.115587	0.000000	51.00
53.00	ANESTHESIOLOGY	80,298	752,611	832,909	0.107419	0.000000	53.00
54.00	RADIOLOGY-DIAGNOSTIC	1,438,901	19,288,063	20,726,964	0.144122	0.000000	54.00
60.00	LABORATORY	1,912,190	21,885,301	23,797,491	0.141013	0.000000	60.00
64.00	INTRAVENOUS THERAPY	29,508	1,882,743	1,912,251	0.690092	0.000000	64.00
65.00	RESPIRATORY THERAPY	910,189	1,590,818	2,501,007	0.322997	0.000000	65.00
65.01	SLEEP DISORDERS	179	8,250,513	8,250,692	0.346317	0.000000	65.01
65.02	GERIATRIC PSYCH	0	630,576	630,576	0.979474	0.000000	65.02
66.00	PHYSICAL THERAPY	106,820	1,801,856	1,908,676	0.364218	0.000000	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	666,975	4,211,239	4,878,214	0.155115	0.000000	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	91,079	553,785	644,864	0.342468	0.000000	72.00
73.00	DRUGS CHARGED TO PATIENTS	2,346,182	10,561,150	12,907,332	0.463320	0.000000	73.00
76.97	CARDIAC REHABILITATION	0	751,516	751,516	0.756438	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	EMERGENCY	432,676	6,966,731	7,399,407	0.393140	0.000000	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	75,562	1,402,497	1,478,059	1.056710	0.000000	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	12,182,273	96,525,448	108,707,721			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	12,182,273	96,525,448	108,707,721			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141334

Period:
From 04/01/2011
To 03/31/2012

Worksheet C
Part I
Date/Time Prepared:
8/21/2012 10:22 am

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
51.00	RECOVERY ROOM	0.000000			51.00
53.00	ANESTHESIOLOGY	0.000000			53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
60.00	LABORATORY	0.000000			60.00
64.00	INTRAVENOUS THERAPY	0.000000			64.00
65.00	RESPIRATORY THERAPY	0.000000			65.00
65.01	SLEEP DISORDERS	0.000000			65.01
65.02	GERIATRIC PSYCH	0.000000			65.02
66.00	PHYSICAL THERAPY	0.000000			66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.97	CARDIAC REHABILITATION	0.000000			76.97
OUTPATIENT SERVICE COST CENTERS					
91.00	EMERGENCY	0.000000			91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	INTEREST EXPENSE				113.00
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: 141334

Period: From 04/01/2011 To 03/31/2012

Worksheet C Part II Date/Time Prepared: 8/21/2012 10:22 am

Cost Center Description		Title XIX			Hospital		
		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	3,762,146	500,299	3,261,847	0	0	50.00
51.00	RECOVERY ROOM	417,834	50,150	367,684	0	0	51.00
53.00	ANESTHESIOLOGY	89,470	6,327	83,143	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	2,987,205	267,191	2,720,014	0	0	54.00
60.00	LABORATORY	3,355,762	212,341	3,143,421	0	0	60.00
64.00	INTRAVENOUS THERAPY	1,319,629	101,597	1,218,032	0	0	64.00
65.00	RESPIRATORY THERAPY	807,818	56,398	751,420	0	0	65.00
65.01	SLEEP DISORDERS	2,857,351	286,293	2,571,058	0	0	65.01
65.02	GERIATRIC PSYCH	617,633	66,504	551,129	0	0	65.02
66.00	PHYSICAL THERAPY	695,174	23,951	671,223	0	0	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	756,682	18,207	738,475	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	220,845	5,050	215,795	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	5,980,223	184,218	5,796,005	0	0	73.00
76.97	CARDIAC REHABILITATION	568,475	90,768	477,707	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	EMERGENCY	2,909,004	316,249	2,592,755	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1,561,879	0	1,561,879	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	INTEREST EXPENSE						113.00
200.00	Subtotal (sum of lines 50 thru 199)	28,907,130	2,185,543	26,721,587	0	0	200.00
201.00	Less Observation Beds	1,561,879	0	1,561,879	0	0	201.00
202.00	Total (line 200 minus line 201)	27,345,251	2,185,543	25,159,708	0	0	202.00

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

Provider CCN: 141334

Period: From 04/01/2011 To 03/31/2012

Worksheet C Part II Date/Time Prepared: 8/21/2012 10:22 am

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)	Cost
		6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	3,762,146	13,107,972	0.287012	50.00
51.00	RECOVERY ROOM	417,834	3,614,894	0.115587	51.00
53.00	ANESTHESIOLOGY	89,470	832,909	0.107419	53.00
54.00	RADIOLOGY-DIAGNOSTIC	2,987,205	20,726,964	0.144122	54.00
60.00	LABORATORY	3,355,762	23,797,491	0.141013	60.00
64.00	INTRAVENOUS THERAPY	1,319,629	1,912,251	0.690092	64.00
65.00	RESPIRATORY THERAPY	807,818	2,501,007	0.322997	65.00
65.01	SLEEP DISORDERS	2,857,351	8,250,692	0.346317	65.01
65.02	GERIATRIC PSYCH	617,633	630,576	0.979474	65.02
66.00	PHYSICAL THERAPY	695,174	1,908,676	0.364218	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	756,682	4,878,214	0.155115	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	220,845	644,864	0.342468	72.00
73.00	DRUGS CHARGED TO PATIENTS	5,980,223	12,907,332	0.463320	73.00
76.97	CARDIAC REHABILITATION	568,475	751,516	0.756438	76.97
OUTPATIENT SERVICE COST CENTERS					
91.00	EMERGENCY	2,909,004	7,399,407	0.393140	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1,561,879	1,478,059	1.056710	92.00
SPECIAL PURPOSE COST CENTERS					
113.00	INTEREST EXPENSE				113.00
200.00	Subtotal (sum of lines 50 thru 199)	28,907,130	0		200.00
201.00	Less Observation Beds	1,561,879	0		201.00
202.00	Total (line 200 minus line 201)	27,345,251	105,342,824		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 141334		Period: From 04/01/2011 To 03/31/2012		Worksheet D Part II Date/Time Prepared: 8/21/2012 10:22 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)	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	500,299	13,107,972	0.038168	379,341	14,479	50.00
51.00	RECOVERY ROOM	50,150	3,614,894	0.013873	93,837	1,302	51.00
53.00	ANESTHESIOLOGY	6,327	832,909	0.007596	41,066	312	53.00
54.00	RADIOLOGY-DIAGNOSTIC	267,191	20,726,964	0.012891	1,114,770	14,371	54.00
60.00	LABORATORY	212,341	23,797,491	0.008923	1,488,307	13,280	60.00
64.00	INTRAVENOUS THERAPY	101,597	1,912,251	0.053130	0	0	64.00
65.00	RESPIRATORY THERAPY	56,398	2,501,007	0.022550	728,504	16,428	65.00
65.01	SLEEP DISORDERS	286,293	8,250,692	0.034699	0	0	65.01
65.02	GERIATRIC PSYCH	66,504	630,576	0.105465	0	0	65.02
66.00	PHYSICAL THERAPY	23,951	1,908,676	0.012548	86,667	1,087	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	18,207	4,878,214	0.003732	397,502	1,483	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	5,050	644,864	0.007831	44,918	352	72.00
73.00	DRUGS CHARGED TO PATIENTS	184,218	12,907,332	0.014272	1,755,178	25,050	73.00
76.97	CARDIAC REHABILITATION	90,768	751,516	0.120780	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	EMERGENCY	316,249	7,399,407	0.042740	37,308	1,595	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,478,059	0.000000	13,972	0	92.00
200.00	Total (lines 50-199)	2,185,543	105,342,824		6,181,370	89,739	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141334

Period:
From 04/01/2011
To 03/31/2012

Worksheet D
Part IV
Date/Time Prepared:
8/21/2012 10:22 am

Cost Center Description		Title XVIII				Hospital	
		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
51.00	RECOVERY ROOM	0	0	0	0	0	51.00
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
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	0	0	0	0	0	65.00
65.01	SLEEP DISORDERS	0	0	0	0	0	65.01
65.02	GERIATRIC PSYCH	0	0	0	0	0	65.02
66.00	PHYSICAL THERAPY	0	0	0	0	0	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	CARDIAC REHABILITATION	0	0	0	0	0	76.97
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: 141334

Period:
From 04/01/2011
To 03/31/2012

Worksheet D
Part IV
Date/Time Prepared:
8/21/2012 10:22 am

Cost Center Description		Title XVIII			Hospital		Cost
		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	13,107,972	0.000000	0.000000	379,341	50.00
51.00	RECOVERY ROOM	0	3,614,894	0.000000	0.000000	93,837	51.00
53.00	ANESTHESIOLOGY	0	832,909	0.000000	0.000000	41,066	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	20,726,964	0.000000	0.000000	1,114,770	54.00
60.00	LABORATORY	0	23,797,491	0.000000	0.000000	1,488,307	60.00
64.00	INTRAVENOUS THERAPY	0	1,912,251	0.000000	0.000000	0	64.00
65.00	RESPIRATORY THERAPY	0	2,501,007	0.000000	0.000000	728,504	65.00
65.01	SLEEP DISORDERS	0	8,250,692	0.000000	0.000000	0	65.01
65.02	GERIATRIC PSYCH	0	630,576	0.000000	0.000000	0	65.02
66.00	PHYSICAL THERAPY	0	1,908,676	0.000000	0.000000	86,667	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,878,214	0.000000	0.000000	397,502	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	644,864	0.000000	0.000000	44,918	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	12,907,332	0.000000	0.000000	1,755,178	73.00
76.97	CARDIAC REHABILITATION	0	751,516	0.000000	0.000000	0	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	EMERGENCY	0	7,399,407	0.000000	0.000000	37,308	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,478,059	0.000000	0.000000	13,972	92.00
200.00	Total (Lines 50-199)	0	105,342,824			6,181,370	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141334

Period:
From 04/01/2011
To 03/31/2012

Worksheet D
Part IV
Date/Time Prepared:
8/21/2012 10:22 am

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
51.00	RECOVERY ROOM	0	0	0	0	0	51.00
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
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	0	0	0	0	0	65.00
65.01	SLEEP DISORDERS	0	0	0	0	0	65.01
65.02	GERIATRIC PSYCH	0	0	0	0	0	65.02
66.00	PHYSICAL THERAPY	0	0	0	0	0	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	CARDIAC REHABILITATION	0	0	0	0	0	76.97
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: 141334	Period: From 04/01/2011 To 03/31/2012	Worksheet D Part IV Date/Time Prepared: 8/21/2012 10:22 am
Title XVIII		Hospital	Cost

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
51.00 RECOVERY ROOM	0	0		51.00
53.00 ANESTHESIOLOGY	0	0		53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00 LABORATORY	0	0		60.00
64.00 INTRAVENOUS THERAPY	0	0		64.00
65.00 RESPIRATORY THERAPY	0	0		65.00
65.01 SLEEP DISORDERS	0	0		65.01
65.02 GERIATRIC PSYCH	0	0		65.02
66.00 PHYSICAL THERAPY	0	0		66.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0		73.00
76.97 CARDIAC REHABILITATION	0	0		76.97
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: 141334	Period: From 04/01/2011 To 03/31/2012	Worksheet D Part V Date/Time Prepared: 8/21/2012 10:22 am
	Title XVIII	Hospital	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges				
		PPS Reimbursed Services (see instructions)	Cost	Cost		
			Reimbursed Services Subject To Ded. & Coins. (see instructions)	Reimbursed Services Not Subject To Ded. & Coins. (see instructions)		
1.00	2.00	3.00	4.00			
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0.287012	0	4,692,642	0		50.00
51.00 RECOVERY ROOM	0.115587	0	1,699,716	0		51.00
53.00 ANESTHESIOLOGY	0.107419	0	293,733	0		53.00
54.00 RADIOLOGY-DIAGNOSTIC	0.144122	0	6,492,390	0		54.00
60.00 LABORATORY	0.141013	0	8,107,794	0		60.00
64.00 INTRAVENOUS THERAPY	0.690092	0	929,040	0		64.00
65.00 RESPIRATORY THERAPY	0.322997	0	784,545	0		65.00
65.01 SLEEP DISORDERS	0.346317	0	2,150,063	0		65.01
65.02 GERIATRIC PSYCH	0.979474	0	626,887	0		65.02
66.00 PHYSICAL THERAPY	0.364218	0	614,330	0		66.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.155115	0	1,360,559	0		71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0.342468	0	201,493	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	0.463320	0	5,268,296	6,957		73.00
76.97 CARDIAC REHABILITATION	0.756438	0	376,758	0		76.97
OUTPATIENT SERVICE COST CENTERS						
91.00 EMERGENCY	0.393140	0	2,310,266	4,030		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	1.056710	0	848,008	0		92.00
200.00 Subtotal (see instructions)		0	36,756,520	10,987		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	36,756,520	10,987		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 141334	Period: From 04/01/2011 To 03/31/2012	Worksheet D Part V Date/Time Prepared: 8/21/2012 10:22 am
	Title XVIII	Hospital	Cost

Cost Center Description	Costs				
	PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)		
	5.00	6.00	7.00		
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	0	1,346,845	0		50.00
51.00 RECOVERY ROOM	0	196,465	0		51.00
53.00 ANESTHESIOLOGY	0	31,553	0		53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	935,696	0		54.00
60.00 LABORATORY	0	1,143,304	0		60.00
64.00 INTRAVENOUS THERAPY	0	641,123	0		64.00
65.00 RESPIRATORY THERAPY	0	253,406	0		65.00
65.01 SLEEP DISORDERS	0	744,603	0		65.01
65.02 GERIATRIC PSYCH	0	614,020	0		65.02
66.00 PHYSICAL THERAPY	0	223,750	0		66.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	211,043	0		71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	69,005	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	0	2,440,907	3,223		73.00
76.97 CARDIAC REHABILITATION	0	284,994	0		76.97
OUTPATIENT SERVICE COST CENTERS					
91.00 EMERGENCY	0	908,258	1,584		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	896,099	0		92.00
200.00 Subtotal (see instructions)	0	10,941,071	4,807		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00 Net Charges (line 200 +/- line 201)	0	10,941,071	4,807		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 141334		Period: From 04/01/2011 To 03/31/2012		Worksheet D Part I Date/Time Prepared: 8/21/2012 10:22 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)	Total Patient Days	Per Diem (col. 3 / col. 4)	Cost
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	894,695	0	894,695	3,971	225.31	30.00
200.00	Total (Lines 30-199)	894,695		894,695	3,971		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 141334		Period: From 04/01/2011 To 03/31/2012		Worksheet D Part I Date/Time Prepared: 8/21/2012 10:22 am	
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	Title XIX	Hospital	Cost	
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	385	86,744				30.00
200.00	Total (Lines 30-199)	385	86,744				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 141334		Period: From 04/01/2011 To 03/31/2012		Worksheet D Part II Date/Time Prepared: 8/21/2012 10:22 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)	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	500,299	13,107,972	0.038168	0	0	50.00
51.00	RECOVERY ROOM	50,150	3,614,894	0.013873	0	0	51.00
53.00	ANESTHESIOLOGY	6,327	832,909	0.007596	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	267,191	20,726,964	0.012891	0	0	54.00
60.00	LABORATORY	212,341	23,797,491	0.008923	0	0	60.00
64.00	INTRAVENOUS THERAPY	101,597	1,912,251	0.053130	0	0	64.00
65.00	RESPIRATORY THERAPY	56,398	2,501,007	0.022550	0	0	65.00
65.01	SLEEP DISORDERS	286,293	8,250,692	0.034699	0	0	65.01
65.02	GERIATRIC PSYCH	66,504	630,576	0.105465	0	0	65.02
66.00	PHYSICAL THERAPY	23,951	1,908,676	0.012548	0	0	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	18,207	4,878,214	0.003732	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	5,050	644,864	0.007831	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	184,218	12,907,332	0.014272	0	0	73.00
76.97	CARDIAC REHABILITATION	90,768	751,516	0.120780	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	EMERGENCY	316,249	7,399,407	0.042740	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,478,059	0.000000	0	0	92.00
200.00	Total (lines 50-199)	2,185,543	105,342,824		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 141334		Period: From 04/01/2011 To 03/31/2012		Worksheet D Part III Date/Time Prepared: 8/21/2012 10:22 am	
Cost Center Description		Nursing School	Allied Health Cost	All Other Medical Education Cost	Hospital Swing-Bed Adjustment Amount (see instructions)	Cost 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: 141334		Period: From 04/01/2011 To 03/31/2012		Worksheet D Part III Date/Time Prepared: 8/21/2012 10:22 am	
Cost Center Description		Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. Nursing School	Cost
		6.00	7.00	8.00	9.00	11.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	3,971	0.00	385	0	0	30.00
200.00	Total (Lines 30-199)	3,971		385	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 141334		Period: From 04/01/2011 To 03/31/2012		Worksheet D Part III Date/Time Prepared: 8/21/2012 10:22 am	
Cost Center Description		PSA Adj . Allied Health Cost	PSA Adj . All Other Medical Education Cost	Title XIX		Hospital Cost	
		12.00	13.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	0	0			30.00	
200.00	Total (lines 30-199)	0	0			200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141334

Period:
From 04/01/2011
To 03/31/2012

Worksheet D
Part IV
Date/Time Prepared:
8/21/2012 10:22 am

Cost Center Description		Title XIX				Hospital	
		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
51.00	RECOVERY ROOM	0	0	0	0	0	51.00
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
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	0	0	0	0	0	65.00
65.01	SLEEP DISORDERS	0	0	0	0	0	65.01
65.02	GERIATRIC PSYCH	0	0	0	0	0	65.02
66.00	PHYSICAL THERAPY	0	0	0	0	0	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	CARDIAC REHABILITATION	0	0	0	0	0	76.97
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: 141334

Period:
From 04/01/2011
To 03/31/2012

Worksheet D
Part IV
Date/Time Prepared:
8/21/2012 10:22 am

Cost Center Description		Title XIX			Hospital		Inpatient Program Charges	
		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Cost		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	OPERATING ROOM	0	13,107,972	0.000000	0.000000		0	50.00
51.00	RECOVERY ROOM	0	3,614,894	0.000000	0.000000		0	51.00
53.00	ANESTHESIOLOGY	0	832,909	0.000000	0.000000		0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	20,726,964	0.000000	0.000000		0	54.00
60.00	LABORATORY	0	23,797,491	0.000000	0.000000		0	60.00
64.00	INTRAVENOUS THERAPY	0	1,912,251	0.000000	0.000000		0	64.00
65.00	RESPIRATORY THERAPY	0	2,501,007	0.000000	0.000000		0	65.00
65.01	SLEEP DISORDERS	0	8,250,692	0.000000	0.000000		0	65.01
65.02	GERIATRIC PSYCH	0	630,576	0.000000	0.000000		0	65.02
66.00	PHYSICAL THERAPY	0	1,908,676	0.000000	0.000000		0	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,878,214	0.000000	0.000000		0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	644,864	0.000000	0.000000		0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	12,907,332	0.000000	0.000000		0	73.00
76.97	CARDIAC REHABILITATION	0	751,516	0.000000	0.000000		0	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	EMERGENCY	0	7,399,407	0.000000	0.000000		0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,478,059	0.000000	0.000000		0	92.00
200.00	Total (lines 50-199)	0	105,342,824				0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141334

Period:
From 04/01/2011
To 03/31/2012

Worksheet D
Part IV
Date/Time Prepared:
8/21/2012 10:22 am

Cost Center Description		Title XIX			Hospital		Cost
		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	0	0	0	0	0	50.00
51.00	RECOVERY ROOM	0	0	0	0	0	51.00
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
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	0	0	0	0	0	65.00
65.01	SLEEP DISORDERS	0	0	0	0	0	65.01
65.02	GERIATRIC PSYCH	0	0	0	0	0	65.02
66.00	PHYSICAL THERAPY	0	0	0	0	0	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	CARDIAC REHABILITATION	0	0	0	0	0	76.97
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: 141334	Period: From 04/01/2011 To 03/31/2012	Worksheet D Part IV Date/Time Prepared: 8/21/2012 10:22 am
	Title XIX	Hospital	Cost

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
51.00 RECOVERY ROOM	0	0		51.00
53.00 ANESTHESIOLOGY	0	0		53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00 LABORATORY	0	0		60.00
64.00 INTRAVENOUS THERAPY	0	0		64.00
65.00 RESPIRATORY THERAPY	0	0		65.00
65.01 SLEEP DISORDERS	0	0		65.01
65.02 GERIATRIC PSYCH	0	0		65.02
66.00 PHYSICAL THERAPY	0	0		66.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0		73.00
76.97 CARDIAC REHABILITATION	0	0		76.97
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: 141334	Period: From 04/01/2011 To 03/31/2012	Worksheet D Part V Date/Time Prepared: 8/21/2012 10:22 am
	Title XIX	Hospital	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges				
		PPS Reimbursed Services (see instructions)	Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)		
			1.00	2.00		
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0.287012	0	0	0		50.00
51.00 RECOVERY ROOM	0.115587	0	0	0		51.00
53.00 ANESTHESIOLOGY	0.107419	0	0	0		53.00
54.00 RADIOLOGY-DIAGNOSTIC	0.144122	0	0	0		54.00
60.00 LABORATORY	0.141013	0	0	0		60.00
64.00 INTRAVENOUS THERAPY	0.690092	0	0	0		64.00
65.00 RESPIRATORY THERAPY	0.322997	0	0	0		65.00
65.01 SLEEP DISORDERS	0.346317	0	0	0		65.01
65.02 GERIATRIC PSYCH	0.979474	0	0	0		65.02
66.00 PHYSICAL THERAPY	0.364218	0	0	0		66.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.155115	0	0	0		71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0.342468	0	0	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	0.463320	0	0	0		73.00
76.97 CARDIAC REHABILITATION	0.756438	0	0	0		76.97
OUTPATIENT SERVICE COST CENTERS						
91.00 EMERGENCY	0.393140	0	0	0		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	1.056710	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: 141334	Period: From 04/01/2011 To 03/31/2012	Worksheet D Part V Date/Time Prepared: 8/21/2012 10:22 am
Title XIX		Hospital	Cost

Cost Center Description	Costs				
	PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)		
	5.00	6.00	7.00		
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	0	0	0		50.00
51.00 RECOVERY ROOM	0	0	0		51.00
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
64.00 INTRAVENOUS THERAPY	0	0	0		64.00
65.00 RESPIRATORY THERAPY	0	0	0		65.00
65.01 SLEEP DISORDERS	0	0	0		65.01
65.02 GERIATRIC PSYCH	0	0	0		65.02
66.00 PHYSICAL THERAPY	0	0	0		66.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.97 CARDIAC REHABILITATION	0	0	0		76.97
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

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141334	Period: From 04/01/2011 To 03/31/2012	Worksheet D-1
		Title XVIII		Hospital
				Cost
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,971	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,971	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		2,998	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		2,072	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			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		6,374,327	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		6,374,327	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		2,066,754	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		2,066,754	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		3.084221	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)		689.38	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		6,374,327	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)		1,605.22	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		3,326,016	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)		3,326,016	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 141334	Period: From 04/01/2011 To 03/31/2012	Worksheet D-1 Date/Time Prepared: 8/21/2012 10:22 am			
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)	
Title XVIII			1.00	2.00	3.00	4.00	5.00	
Hospital								
Cost								
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)						1,681,219	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						5,007,235	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)						973	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						1,605.22	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)						1,561,879	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141334		Period: From 04/01/2011 To 03/31/2012		Worksheet D-1 Date/Time Prepared: 8/21/2012 10:22 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: 141334	Period: From 04/01/2011 To 03/31/2012	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 8/21/2012 10:22 am
Cost Center Description			Cost	
			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,971	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,971	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		2,998	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)		385	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			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		6,374,327	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		6,374,327	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		2,066,754	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		2,066,754	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		3.084221	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)		689.38	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		6,374,327	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)		1,605.22	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		618,010	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)		618,010	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 141334	Period: From 04/01/2011 To 03/31/2012	Worksheet D-1 Date/Time Prepared: 8/21/2012 10:22 am	
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
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT					43.00
44.00	CORONARY CARE UNIT					44.00
45.00	BURN INTENSIVE CARE UNIT					45.00
46.00	SURGICAL INTENSIVE CARE UNIT					46.00
47.00	OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description						
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					618,010
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0
52.00	Total Program excludable cost (sum of lines 50 and 51)					0
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0
55.00	Target amount per discharge					0.00
56.00	Target amount (line 54 x line 55)					0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00	Bonus payment (see instructions)					0
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0
62.00	Relief payment (see instructions)					0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)					70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00	Program routine service cost (line 9 x line 71)					72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00	Program capital-related costs (line 9 x line 76)					77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00	Inpatient routine service cost per diem limitation					81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00	Reasonable inpatient routine service costs (see instructions)					83.00
84.00	Program inpatient ancillary services (see instructions)					84.00
85.00	Utilization review - physician compensation (see instructions)					85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)					973
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,605.22
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,561,879

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141334		Period: From 04/01/2011 To 03/31/2012		Worksheet D-1 Date/Time Prepared: 8/21/2012 10:22 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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 141334	Period: From 04/01/2011 To 03/31/2012	Worksheet D-3 Date/Time Prepared: 8/21/2012 10:22 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS		1,377,239		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.287012	379,341	108,875	50.00
51.00	RECOVERY ROOM	0.115587	93,837	10,846	51.00
53.00	ANESTHESIOLOGY	0.107419	41,066	4,411	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.144122	1,114,770	160,663	54.00
60.00	LABORATORY	0.141013	1,488,307	209,871	60.00
64.00	INTRAVENOUS THERAPY	0.690092	0	0	64.00
65.00	RESPIRATORY THERAPY	0.322997	728,504	235,305	65.00
65.01	SLEEP DISORDERS	0.346317	0	0	65.01
65.02	GERIATRIC PSYCH	0.979474	0	0	65.02
66.00	PHYSICAL THERAPY	0.364218	86,667	31,566	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.155115	397,502	61,659	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.342468	44,918	15,383	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.463320	1,755,178	813,209	73.00
76.97	CARDIAC REHABILITATION	0.756438	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
91.00	EMERGENCY	0.393140	37,308	14,667	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.056710	13,972	14,764	92.00
200.00	Total (sum of lines 50-94 and 96-98)		6,181,370	1,681,219	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)		6,181,370		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 141334	Period: From 04/01/2011 To 03/31/2012	Worksheet D-3 Date/Time Prepared: 8/21/2012 10:22 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS		0		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.287012	0	0	50.00
51.00	RECOVERY ROOM	0.115587	0	0	51.00
53.00	ANESTHESIOLOGY	0.107419	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.144122	0	0	54.00
60.00	LABORATORY	0.141013	0	0	60.00
64.00	INTRAVENOUS THERAPY	0.690092	0	0	64.00
65.00	RESPIRATORY THERAPY	0.322997	0	0	65.00
65.01	SLEEP DISORDERS	0.346317	0	0	65.01
65.02	GERIATRIC PSYCH	0.979474	0	0	65.02
66.00	PHYSICAL THERAPY	0.364218	0	0	66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.155115	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.342468	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.463320	0	0	73.00
76.97	CARDIAC REHABILITATION	0.756438	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
91.00	EMERGENCY	0.393140	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.056710	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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 141334	Period: From 04/01/2011 To 03/31/2012	Worksheet E Part B Date/Time Prepared: 8/21/2012 10:22 am
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			10,945,878 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)			10,945,878 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)			11,055,337 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)			62,169 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			5,766,010 26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)			5,227,158 27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)			0 28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)			0 29.00
30.00	Subtotal (sum of lines 27 through 29)			5,227,158 30.00
31.00	Primary payer payments			814 31.00
32.00	Subtotal (line 30 minus line 31)			5,226,344 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)			1,292,257 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			1,292,257 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)			6,518,601 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)			6,518,601 40.00
41.00	Interim payments			5,899,450 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)			619,151 43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			93,689 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: 141334	Period: From 04/01/2011 To 03/31/2012	Worksheet E Part B Date/Time Prepared: 8/21/2012 10:22 am
		Title XVIII	Hospital
			Cost
			Overrides
112.00			1.00
112.00			0

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: 141334

Period:
From 04/01/2011
To 03/31/2012

Worksheet E-1
Part I
Date/Time Prepared:
8/21/2012 10:22 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		5,256,164		6,444,756	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		12/16/2011	360,910	03/16/2012	192,245	3.02	
3.03		03/16/2012	111,643		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM	06/10/2011	97,742	12/16/2011	737,551	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)		374,811		-545,306	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)		5,630,975		5,899,450	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		619,151	6.01	
6.02	SETTLEMENT TO PROGRAM		927,055		0	6.02	
7.00	Total Medicare program liability (see instructions)		4,703,920		6,518,601	7.00	
				Contractor Number	Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor						8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 141334	Period: From 04/01/2011 To 03/31/2012	Worksheet E-3 Part V Date/Time Prepared: 8/21/2012 10:22 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			5,007,235 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)			5,007,235 4.00
5.00	Primary payer payments			446 5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			5,056,861 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)			5,056,861 19.00
20.00	Deductibles (exclude professional component)			436,884 20.00
21.00	Excess reasonable cost (from line 16)			0 21.00
22.00	Subtotal (line 19 minus line 20)			4,619,977 22.00
23.00	Coinsurance			5,660 23.00
24.00	Subtotal (line 22 minus line 23)			4,614,317 24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			89,603 25.00
26.00	Adjusted reimbursable bad debts (see instructions)			89,603 26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)			4,703,920 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)			4,703,920 30.00
31.00	Interim payments			5,630,975 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)			-927,055 33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2			42,850 34.00

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

Provider CCN: 141334

Period:
From 04/01/2011
To 03/31/2012

Worksheet G
Date/Time Prepared:
8/21/2012 10:22 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	2,275,626	1,953	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	19,688	0	0	0	3.00
4.00	Accounts receivable	30,871,824	0	0	0	4.00
5.00	Other receivable	62,475	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-20,769,918	0	0	0	6.00
7.00	Inventory	573,455	0	0	0	7.00
8.00	Prepaid expenses	130,721	0	0	0	8.00
9.00	Other current assets	2,706	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	13,166,577	1,953	0	0	11.00
FIXED ASSETS						
12.00	Land	171,136	0	0	0	12.00
13.00	Land improvements	873,563	0	0	0	13.00
14.00	Accumulated depreciation	-493,888	0	0	0	14.00
15.00	Buildings	18,294,214	0	0	0	15.00
16.00	Accumulated depreciation	-6,613,351	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	57,972	0	0	0	21.00
22.00	Accumulated depreciation	-26,744	0	0	0	22.00
23.00	Major movable equipment	11,205,334	0	0	0	23.00
24.00	Accumulated depreciation	-7,628,493	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	970,214	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	16,809,957	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	16,679,097	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	442,964	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	17,122,061	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	47,098,595	1,953	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,155,827	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	1,551,264	0	0	0	39.00
40.00	Notes and loans payable (short term)	394,246	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	665,691	0	0	0	43.00
44.00	Other current liabilities	384,753	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,151,781	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	11,437,531	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	515,805	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	11,953,336	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	16,105,117	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	30,993,478				52.00
53.00	Specific purpose fund		1,953			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	30,993,478	1,953	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	47,098,595	1,953	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 141334

Period:
From 04/01/2011
To 03/31/2012

Worksheet G-1

Date/Time Prepared:
8/21/2012 10:22 am

		General Fund		Special Purpose Fund		
		1.00	2.00	3.00	4.00	
		1.00	Fund balances at beginning of period		30,510,641	
2.00	Net income (loss) (From Wkst. G-3, line 29)		1,421,340			2.00
3.00	Total (sum of line 1 and line 2)		31,931,981		126	3.00
4.00	Additions (credit adjustments) (specify)	0		0		4.00
5.00		0		0		5.00
6.00	RESTRICTED GRANTS	0		1,953		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		0		1,953	10.00
11.00	Subtotal (line 3 plus line 10)		31,931,981		2,079	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00		0		0		13.00
14.00	TRANSFERS	938,503		126		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)		938,503		126	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		30,993,478		1,953	19.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 141334

Period:
From 04/01/2011
To 03/31/2012

Worksheet G-1

Date/Time Prepared:
8/21/2012 10:22 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 Additions (credit adjustments) (specify)	0		0			4.00
5.00	0		0			5.00
6.00 RESTRICTED GRANTS	0		0			6.00
7.00	0		0			7.00
8.00	0		0			8.00
9.00	0		0			9.00
10.00 Total additions (sum of line 4-9)		0		0		10.00
11.00 Subtotal (line 3 plus line 10)		0		0		11.00
12.00 Deductions (debit adjustments) (specify)	0		0			12.00
13.00	0		0			13.00
14.00 TRANSFERS	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: 141334

Period:
From 04/01/2011
To 03/31/2012

Worksheet G-2 Parts

Date/Time Prepared:
8/21/2012 10:22 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	4,860,597		4,860,597	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)	4,860,597		4,860,597	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)	4,860,597		4,860,597	17.00
18.00	Ancillary services	8,583,601	97,353,712	105,937,313	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)	13,444,198	97,353,712	110,797,910	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		32,390,457		29.00
30.00	ADD (SPECIFY)	0			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)		0		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)		32,390,457		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 141334

Period:
From 04/01/2011
To 03/31/2012

Worksheet G-3

Date/Time Prepared:
8/21/2012 10:22 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	110,797,910	1.00
2.00	Less contractual allowances and discounts on patients' accounts	66,322,644	2.00
3.00	Net patient revenues (line 1 minus line 2)	44,475,266	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	32,390,457	4.00
5.00	Net income from service to patients (line 3 minus line 4)	12,084,809	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	8,790	6.00
7.00	Income from investments	-404,717	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	3,420	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	76,771	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	473	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	18,052	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	8,062	20.00
21.00	Rental of vending machines	8,270	21.00
22.00	Rental of hospital space	33,942	22.00
23.00	Governmental appropriations	31,530	23.00
24.00	MISCELLANEOUS	700	24.00
24.01	ROUNDING	3	24.01
25.00	Total other income (sum of lines 6-24)	-214,704	25.00
26.00	Total (line 5 plus line 25)	11,870,105	26.00
27.00	LOSS ON SALE OF EQUIPMENT	23,290	27.00
27.01	CORPORATE ALLOCATION	10,425,475	27.01
27.02		0	27.02
28.00	Total other expenses (sum of line 27 and subscripts)	10,448,765	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,421,340	29.00