

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

Provider CCN: 264012

Period: From 01/01/2011 To 12/31/2011

FORM APPROVED OMB NO. 0938-0050 Worksheet S Parts I-III Date/Time Prepared: 5/30/2012 9:29 am

PART I - COST REPORT STATUS

Provider use only: 1. [X] Electronically filed cost report Date: 5/30/2012 Time: 9:29 am
2. [] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.
Contractor use only: 5. [0] 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) [N] Initial Report for this Provider CCN (9) [N] Final Report for this Provider CCN
10. NPR Date: 11. Contractor's Vendor Code: 04
12. [0] 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 CENTERPOINTE HOSPITAL for the cost reporting period beginning 01/01/2011 and ending 12/31/2011 and to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services identified in this cost report were provided in compliance with such laws and regulations.

Encryption Information

ECR: Date: 5/30/2012 Time: 9:29 am
55jGrmcqg41X4z3oeODW8trVTDZM0
aN0bK0a0BEnqPEQ9F0bEysjHCvWjSb
Rvrz0ds1Bz0kFxfy
PI: Date: 5/30/2012 Time: 9:29 am
tiY5xeV6AxBB7tkPpkHMrpxtpy.Z20
OpexX0i0jSAe0hdVHCe7rw0xFWWot6
Z5PasP84dh0oub4A

(Signed)

Office or Administrator of Provider(s)

Title

Date

[Signature] CFO 05/30/2012

Table with columns: Title V, Title XVIII (Part A, Part B), HIT, Title XIX, and a final column. Rows include Hospital, Subprovider - IPF, Subprovider - IRF, SUBPROVIDER I, Swing bed - SNF, Swing bed - NF, SKILLED NURSING FACILITY, NURSING FACILITY, HOME HEALTH AGENCY I, RURAL HEALTH CLINIC I, FEDERALLY QUALIFIED HEALTH CENTER I, CMHC I, and Total.

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.

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 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

Provider CCN: 264012
 Period: From 01/01/2011 To 12/31/2011
 Worksheet S Parts I-III
 Date/Time Prepared: 5/29/2012 1:24 pm

PART I - COST REPORT STATUS

Provider use only: 1. Electronically filed cost report
 2. Manually submitted cost report
 3. If this is an amended report enter the number of times the provider resubmitted this cost report
 4. Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only: 5. Cost Report Status
 (1) As Submitted
 (2) Settled without Audit
 (3) Settled with Audit
 (4) Reopened
 (5) Amended

6. Date Received:
 7. Contractor No.
 8. Initial Report for this Provider CCN
 9. Final Report for this Provider CCN

10. NPR Date:
 11. Contractor's Vendor Code: 04
 12. If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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(Signed) *J. Walsh*
 Officer or Administrator of Provider(s)
 Title CEO
 Date 05/30/2012

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	107,133	102,187	0	1,343,077	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	107,133	102,187	0	1,343,077	200.00

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		1.00	2.00	3.00	4.00					
Hospital and Hospital Health Care Complex Address:										
1.00	Street:4801 WELDON SPRINGS PARKWAY	PO Box:		Zip Code:63304		County: ST CHARLES		1.00		
2.00	City: ST CHARLES	State: MO						2.00		
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
							V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
Hospital and Hospital-Based Component Identification:										
3.00	Hospital	CENTERPOINTE HOSPITAL	264012	41180	4	12/31/1980	N	P	O	
4.00	Subprovider - IPF									
5.00	Subprovider - IRF									
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF						N	N	N	
8.00	Swing Beds - NF						N			
9.00	Hospital-Based SNF									
10.00	Hospital-Based NF									
11.00	Hospital-Based OLTC									
12.00	Hospital-Based HHA									
13.00	Separately Certified ASC									
14.00	Hospital-Based Hospice									
15.00	Hospital-Based Health Clinic - RHC									
16.00	Hospital-Based Health Clinic - FQHC									
17.00	Hospital-Based (CMHC) 1									
18.00	Renal Dialysis									
19.00	Other									
						From:	To:			
						1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)					01/01/2011	12/31/2011		20.00	
21.00	Type of Control (see instructions)					4				21.00
Inpatient PPS Information										
22.00	Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N		22.00	
23.00	Indicate in column 1 the method used to capture Medicaid (title XIX) days reported on lines 24 and/or 25 of this worksheet during the cost reporting period by entering a "1" if days are based on the date of admission, "2" if days are based on census days (also referred to as the day count), or "3" if the days are based on the date of discharge. Is the method of identifying the days in the current cost reporting period different from the method used in the prior cost reporting period? Enter in column 2 "Y" for yes or "N" for no.					3	N		23.00	
		In-State Medicaid paid days	In-State Medicaid eligible days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible days	Medicaid HMO days	Other Medicaid days			
24.00	If line 22 and/or line 45 is "yes", and this provider is an IPPS hospital enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible days in col. 4, Medicaid HMO days in col. 5, and other Medicaid days in col. 6.	1.00 4,623	2.00 4,623	3.00 2,053	4.00 2,053	5.00 425	6.00 0		24.00	
25.00	If this provider is an IRF, enter the in-State Medicaid paid days in column 1, the in State Medicaid eligible days in column 2, the out of State Medicaid paid days in column 3, the out of State Medicaid eligible days in column 4, Medicaid HMO days in column 5, and other Medicaid days in column 6. For all columns include in these days the labor and delivery days.	0	0	0	0	0	0		25.00	
						Urban/Rural	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.					1			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).					1			27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0			35.00	
						Beginning:	Ending:			
						1.00	2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.									36.00

		Beginning:	Ending:	
		1.00	2.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0		37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.			38.00

V	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	Y	Y	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.	Y			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	N	0.00	0.00

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)				61.00
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ACA Provisions Affecting the Health Resources and Services Administration (HRSA)

62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00			62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00			62.01

Teaching Hospitals that Claim Residents in Non-Provider Settings

63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete lines 64-67. (see instructions)	N			63.00
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))	
		1.00	2.00	3.00	

Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.

64.00	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
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	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

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

		1.00	2.00	3.00	
Inpatient Rehabilitation Facility PPS					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			0	76.00
		1.00			
Long Term Care Hospital PPS					
80.00	Is this a Long Term Care Hospital (LTCH)? Enter "Y" for yes or "N" for no.		N		80.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		N		86.00
		V	XIX		
		1.00	2.00		
Title V or XIX Inpatient Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N		Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N		N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N		N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N		N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	97.00
Rural Providers					
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	N			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)				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)				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
119.00	What is the liability limit for the malpractice insurance policy? Enter in column 1 the monetary limit per lawsuit. Enter in column 2 the monetary limit per policy year.	1,000,000		3,000,000	119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 as amended by the Medicaid Extender Act (MMEA) §108? Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with <= 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121? Enter in column 2 "Y" for yes or "N" for no.	N		N	120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N			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.	1.00	2.00	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)	N		140.00				
		1.00	2.00	3.00				
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.								
141.00	Name:	Contractor's Name:		141.00				
142.00	Street:	PO Box:		142.00				
143.00	City:	State:		143.00				
		Zip Code:						
144.00	Are provider based physicians' costs included in worksheet A?		1.00	144.00				
145.00	If costs for renal services are claimed on Worksheet A, are they costs for inpatient services only?		Y N	145.00				
Enter "Y" for yes or "N" for no.								
146.00	Has the cost allocation methodology changed from the previously filed cost report?	1.00	2.00	146.00				
	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						
147.00	was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N		147.00				
148.00	was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N		148.00				
149.00	was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N		149.00				
		Part A	Part B					
		1.00	2.00					
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)								
155.00	Hospital	N	N	155.00				
156.00	Subprovider - IPF	N	N	156.00				
157.00	Subprovider - IRF	N	N	157.00				
158.00	SUBPROVIDER	N	N	158.00				
159.00	SNF	N	N	159.00				
160.00	HOME HEALTH AGENCY	N	N	160.00				
161.00	CMHC		N	161.00				
1.00								
Multicampus								
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs?	N			165.00			
Enter "Y" for yes or "N" for no.								
		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)				0.00169.00			

		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)	N		3.00
		Y/N	Type	Date
		1.00	2.00	3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	05/31/2012
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
		Y/N	Legal Oper.	
		1.00	2.00	
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.			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.			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.			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.		Y	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	05/18/2012	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

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

		Part B		
		Y/N	Date	
		3.00	4.00	
	PS&R Data			
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	05/18/2012	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

Cost Center Description	Worksheet A	No. of Beds	Bed Days	CAH Hours	
	Line Number		Available		
	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	104	37,960	0.00	1.00
2.00 HMO					2.00
3.00 HMO IPF					3.00
4.00 HMO IRF					4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					5.00
6.00 Hospital Adults & Peds. Swing Bed NF					6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		104	37,960	0.00	7.00
8.00 INTENSIVE CARE UNIT	31.00	0	0	0.00	8.00
8.01 CHEMICAL DEPENDENCY	31.01	32	11,600	0.00	8.01
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	49,560	0.00	14.00
15.00 CAH visits					15.00
16.00 SUBPROVIDER - IPF					16.00
17.00 SUBPROVIDER - IRF					17.00
18.00 SUBPROVIDER					18.00
19.00 SKILLED NURSING FACILITY					19.00
20.00 NURSING FACILITY					20.00
21.00 OTHER LONG TERM CARE					21.00
22.00 HOME HEALTH AGENCY					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)					23.00
24.00 HOSPICE					24.00
25.00 CMHC - CMHC					25.00
26.00 RURAL HEALTH CLINIC					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER					26.25
27.00 Total (sum of lines 14-26)		136			27.00
28.00 Observation Bed Days					28.00
29.00 Ambulance Trips					29.00
30.00 Employee discount days (see instruction)					30.00
31.00 Employee discount days - IRF					31.00
32.00 Labor & delivery days (see instructions)					32.00
33.00 LTCH non-covered days					33.00

Cost Center Description	I/P Days / O/P Visits / Trips				Total All Patients	
	Title V	Title XVIII	Title XIX			
	5.00	6.00	7.00	8.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	0	6,424	7,101	25,408	1.00	
2.00 HMO		71	425		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	6,424	7,101	25,408	7.00	
8.00 INTENSIVE CARE UNIT	0	0	0	0	8.00	
8.01 CHEMICAL DEPENDENCY	0	0	0	3,426	8.01	
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	6,424	7,101	28,834	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 (O.P.)					23.00	
24.00 HOSPICE					24.00	
25.00 CMHC - CMHC					25.00	
26.00 RURAL HEALTH CLINIC					26.00	
26.25 FEDERALLY QUALIFIED HEALTH CENTER					26.25	
27.00 Total (sum of lines 14-26)					27.00	
28.00 Observation Bed Days	0		0	0	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	

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	505	1.00
2.00 HMO					8	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
8.01 CHEMICAL DEPENDENCY						8.01
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	287.00	0.00	0	505	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	287.00	0.00			27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

Cost Center Description	Discharges		
	Title XIX	Total All Patients	
	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	560	2,294	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
8.01 CHEMICAL DEPENDENCY			8.01
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)	560	2,294	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

Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
	1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS						
1.00		69,846	69,846	1,345,537	1,415,383	1.00
2.00		428,131	428,131	298,568	726,699	2.00
3.00		0	0	0	0	3.00
4.00	156,011	3,612,278	3,768,289	-8,253	3,760,036	4.00
5.00	3,221,319	4,971,676	8,192,995	-1,110,543	7,082,452	5.00
6.00	200,756	505,819	706,575	45,692	752,267	6.00
8.00	0	52,890	52,890	0	52,890	8.00
9.00	0	274,625	274,625	-2,970	271,655	9.00
10.00	273,959	642,915	916,874	0	916,874	10.00
11.00	0	0	0	0	0	11.00
13.00	752,492	25,007	777,499	-6,356	771,143	13.00
15.00	13,066	921,846	934,912	0	934,912	15.00
16.00	286,612	231,150	517,762	-53,980	463,782	16.00
17.00	506,785	3,243	510,028	-14	510,014	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	5,765,741	1,432,857	7,198,598	44,094	7,242,692	30.00
31.00	0	0	0	0	0	31.00
31.01	638,744	253,678	892,422	12,051	904,473	31.01
ANCILLARY SERVICE COST CENTERS						
54.00	0	33,907	33,907	-33,907	0	54.00
57.00	0	0	0	0	0	57.00
60.00	0	111,727	111,727	-111,727	0	60.00
69.00	0	0	0	0	0	69.00
70.00	0	0	0	74,081	74,081	70.00
73.00	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00	0	0	0	0	0	90.00
90.01	3,753,018	2,155,379	5,908,397	-601,732	5,306,665	90.01
SPECIAL PURPOSE COST CENTERS						
113.00		1,027	1,027	-1,027	0	113.00
118.00	15,568,503	15,728,001	31,296,504	-110,486	31,186,018	118.00
NONREIMBURSABLE COST CENTERS						
192.00	0	0	0	0	0	192.00
192.01	0	0	0	110,486	110,486	192.01
200.00	15,568,503	15,728,001	31,296,504	0	31,296,504	200.00

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	0	1,415,383	1.00
2.00 CAP REL COSTS-MVBLE EQUIP	-32,804	693,895	2.00
3.00 OTHER CAP REL COSTS	0	0	3.00
4.00 EMPLOYEE BENEFITS	-61,337	3,698,699	4.00
5.00 ADMINISTRATIVE & GENERAL	-1,321,277	5,761,175	5.00
6.00 MAINTENANCE & REPAIRS	-4,831	747,436	6.00
8.00 LAUNDRY & LINEN SERVICE	0	52,890	8.00
9.00 HOUSEKEEPING	0	271,655	9.00
10.00 DIETARY	-46,386	870,488	10.00
11.00 CAFETERIA	0	0	11.00
13.00 NURSING ADMINISTRATION	0	771,143	13.00
15.00 PHARMACY	0	934,912	15.00
16.00 MEDICAL RECORDS & LIBRARY	-952	462,830	16.00
17.00 SOCIAL SERVICE	0	510,014	17.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00 ADULTS & PEDIATRICS	-931,033	6,311,659	30.00
31.00 INTENSIVE CARE UNIT	0	0	31.00
31.01 CHEMICAL DEPENDENCY	-202,325	702,148	31.01
ANCILLARY SERVICE COST CENTERS			
54.00 RADIOLOGY-DIAGNOSTIC	0	0	54.00
57.00 CT SCAN	0	0	57.00
60.00 LABORATORY	0	0	60.00
69.00 ELECTROCARDIOLOGY	0	0	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	74,081	70.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	73.00
OUTPATIENT SERVICE COST CENTERS			
90.00 CLINIC	0	0	90.00
90.01 OUTPATIENT	-287,948	5,018,717	90.01
SPECIAL PURPOSE COST CENTERS			
113.00 INTEREST EXPENSE	0	0	113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	-2,888,893	28,297,125	118.00
NONREIMBURSABLE COST CENTERS			
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	192.00
192.01 COMMUNITY RELATIONS	0	110,486	192.01
200.00 TOTAL (SUM OF LINES 118-199)	-2,888,893	28,407,611	200.00

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
1.00	A - DEFAULT				
		0.00	0	0	1.00
	TOTALS		0	0	
AA - RECLASS COMMUNICATION COSTS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	44,081	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
	TOTALS		0	44,081	
BB - TO RECLASS LEASES					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	212,401	1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,324,805	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
	TOTALS		0	1,537,206	
CC - TO RECLASS LAB EXP.					
1.00	ADULTS & PEDIATRICS	30.00	0	102,482	1.00
2.00	CHEMICAL DEPENDENCY	31.01	0	9,245	2.00
	TOTALS		0	111,727	
DD - TO RECLASS PUBLIC RELATIONS EXP					
1.00	COMMUNITY RELATIONS	192.01	64,655	45,831	1.00
	TOTALS		64,655	45,831	
EE - TO RECLASS PROPERTY TAX					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	20,732	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	86,167	2.00
	TOTALS		0	106,899	
FF - RECLASS ECT EXPENSES					
1.00	ELECTROENCEPHALOGRAPHY	70.00	0	74,081	1.00
	TOTALS		0	74,081	
GG - RECLASS INTEREST EXPENSE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,027	1.00
	TOTALS		0	1,027	
JJ - RECLASS RADIOLOGY EXP					
1.00	ADULTS & PEDIATRICS	30.00	0	31,101	1.00
2.00	CHEMICAL DEPENDENCY	31.01	0	2,806	2.00
	TOTALS		0	33,907	
LL - RECLASS TRANSPORT SALARIES TO A&G					
1.00	MAINTENANCE & REPAIRS	6.00	90,261	0	1.00
	TOTALS		90,261	0	
500.00	Grand Total: Increases		154,916	1,954,759	500.00

		Decreases				
Cost Center		Line #	Salary	Other	Wkst. A-7 Ref.	
6.00		7.00	8.00	9.00	10.00	
A - DEFAULT						
1.00		0.00	0	0	0	1.00
TOTALS			0	0		
AA - RECLASS COMMUNICATION COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	98	0	1.00
2.00	MAINTENANCE & REPAIRS	6.00	0	10,339	0	2.00
3.00	MEDICAL RECORDS & LIBRARY	16.00	0	2,188	0	3.00
4.00	SOCIAL SERVICE	17.00	0	14	0	4.00
5.00	OUTPATIENT	90.01	0	31,442	0	5.00
TOTALS			0	44,081		
BB - TO RECLASS LEASES						
1.00	EMPLOYEE BENEFITS	4.00	0	8,253	10	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	938,168	10	2.00
3.00	MAINTENANCE & REPAIRS	6.00	0	34,230	0	3.00
4.00	HOUSEKEEPING	9.00	0	2,970	0	4.00
5.00	NURSING ADMINISTRATION	13.00	0	6,356	0	5.00
6.00	MEDICAL RECORDS & LIBRARY	16.00	0	51,792	0	6.00
7.00	ADULTS & PEDIATRICS	30.00	0	15,408	0	7.00
8.00	OUTPATIENT	90.01	0	480,029	0	8.00
TOTALS			0	1,537,206		
CC - TO RECLASS LAB EXP.						
1.00	LABORATORY	60.00	0	111,727	0	1.00
2.00		0.00	0	0	0	2.00
TOTALS			0	111,727		
DD - TO RECLASS PUBLIC RELATIONS EXP						
1.00	ADMINISTRATIVE & GENERAL	5.00	64,655	45,831	0	1.00
TOTALS			64,655	45,831		
EE - TO RECLASS PROPERTY TAX						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	106,899	13	1.00
2.00		0.00	0	0	13	2.00
TOTALS			0	106,899		
FF - RECLASS ECT EXPENSES						
1.00	ADULTS & PEDIATRICS	30.00	0	74,081	0	1.00
TOTALS			0	74,081		
GG - RECLASS INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	1,027	0	1.00
TOTALS			0	1,027		
JJ - RECLASS RADIOLOGY EXP						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	33,907	0	1.00
2.00		0.00	0	0	0	2.00
TOTALS			0	33,907		
LL - RECLASS TRANSPORT SALARIES TO A&G						
1.00	OUTPATIENT	90.01	90,261	0	0	1.00
TOTALS			90,261	0		
500.00	Grand Total: Decreases		154,916	1,954,759		500.00

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	0	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	0	3.00
4.00	Building Improvements	546,051	280,130	0	280,130	0	4.00
5.00	Fixed Equipment	2,744,155	689,591	0	689,591	0	5.00
6.00	Movable Equipment	0	0	0	0	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	3,290,206	969,721	0	969,721	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	3,290,206	969,721	0	969,721	0	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	69,846	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	428,131	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	497,977	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	0	0	0	1.000000	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1.000000	0	3.00

		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	0	0				1.00
2.00	Land Improvements	0	0				2.00
3.00	Buildings and Fixtures	0	0				3.00
4.00	Building Improvements	826,181	0				4.00
5.00	Fixed Equipment	3,433,746	0				5.00
6.00	Movable Equipment	0	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	4,259,927	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	4,259,927	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	69,846				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	428,131				2.00
3.00	Total (sum of lines 1-2)	0	497,977				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	69,846	1,324,805	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	428,131	212,401	2.00
3.00	Total (sum of lines 1-2)	0	0	0	497,977	1,537,206	3.00

Provider CCN: 264012

Period:
 From 01/01/2011
 To 12/31/2011

Worksheet A-7
 Parts I-III
 Date/Time Prepared:
 5/29/2012 1:24 pm

Cost Center Description	SUMMARY OF CAPITAL					Total (2) (sum of cols. 9 through 14)	
	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Relat ed 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	20,732	0	1,415,383	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	86,167	-32,804	693,895	2.00
3.00	Total (sum of lines 1-2)	0	0	106,899	-32,804	2,109,278	3.00

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
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	2.00
3.00 Investment income - other (chapter 2)	B	-1,027	ADMINISTRATIVE & GENERAL	5.00	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	-2,509,806			10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0		0.00	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	0			12.00
13.00 Laundry and linen service		0		0.00	13.00
14.00 Cafeteria-employees and guests	B	-46,386	DIETARY	10.00	14.00
15.00 Rental of quarters to employee and others		0		0.00	15.00
16.00 Sale of medical and surgical supplies to other than patients	B	-952	MEDICAL RECORDS & LIBRARY	16.00	16.00
17.00 Sale of drugs to other than patients		0		0.00	17.00
18.00 Sale of medical records and abstracts		0		0.00	18.00
19.00 Nursing school (tuition, fees, books, etc.)		0		0.00	19.00
20.00 Vending machines	B	-4,831	MAINTENANCE & REPAIRS	6.00	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	65.00	23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	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		0	CAP REL COSTS-BLDG & FIXT	1.00	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	27.00
28.00 Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00	28.00
29.00 Physicians' assistant		0		0.00	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00	30.00
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00	31.00
32.00 CAH HIT Adjustment for Depreciation and Interest	A	0		0.00	32.00
33.00 MHA LOBBYING EXPENSE	A	-5,350	ADMINISTRATIVE & GENERAL	5.00	33.00
33.01 FRA RECOUPEMENT	B	1,581,528	ADMINISTRATIVE & GENERAL	5.00	33.01
33.02 SIGNATURE SERVICE AGREEMENT	B	-41,688	ADMINISTRATIVE & GENERAL	5.00	33.02
33.03 OTHER INCOME	B	-45,975	ADMINISTRATIVE & GENERAL	5.00	33.03
33.04 DONATIONS & GIFTS	B	-16,410	ADMINISTRATIVE & GENERAL	5.00	33.04
33.05 TRANSPORTATION EXPENSES	A	-429,457	ADMINISTRATIVE & GENERAL	5.00	33.05
33.06 TRANSPORTATION BENEFITS	A	-1,476	EMPLOYEE BENEFITS	4.00	33.06
33.07 BAD DEBTS	A	-1,525,079	ADMINISTRATIVE & GENERAL	5.00	33.07
33.08 O/P TRANSPORTATION SALARIES	A	-287,948	OUTPATIENT	90.01	33.08
33.09 O/P TRANSPORTATION BENEFITS	A	-59,861	EMPLOYEE BENEFITS	4.00	33.09
33.10 TRANSPORTATION VEHICLES DEPRECIATION	A	-32,804	CAP REL COSTS-MVBLE EQUIP	2.00	33.10
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200.)		-3,427,522			50.00

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	MHA LOBBYING EXPENSE	0	33.00
33.01	FRA RECOUPEMENT	0	33.01
33.02	SIGNATURE SERVICE AGREEMENT	0	33.02
33.03	OTHER INCOME	0	33.03
33.04	DONATIONS & GIFTS	0	33.04
33.05	TRANSPORTATION EXPENSES	0	33.05
33.06	TRANSPORTATION BENEFITS	0	33.06
33.07	BAD DEBTS	0	33.07
33.08	O/P TRANSPORTATION SALARIES	0	33.08
33.09	O/P TRANSPORTATION BENEFITS	0	33.09
33.10	TRANSPORTATION VEHICLES DEPRECIATION	14	33.10
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200.)		50.00

	wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
	1.00	2.00	3.00	4.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	837,819	837,819	1.00
2.00	30.00	ADULTS & PEDIATRICS	931,033	931,033	2.00
3.00	31.01	CHEMICAL DEPENDENCY	202,325	202,325	3.00
4.00	0.00		538,629	538,629	4.00
5.00	0.00		0	0	5.00
6.00	0.00		0	0	6.00
7.00	0.00		0	0	7.00
8.00	0.00		0	0	8.00
9.00	0.00		0	0	9.00
10.00	0.00		0	0	10.00
200.00			2,509,806	2,509,806	200.00

	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
2.00	0	0	0	0	0
3.00	0	0	0	0	0
4.00	0	0	0	0	0
5.00	0	0	0	0	0
6.00	0	0	0	0	0
7.00	0	0	0	0	0
8.00	0	0	0	0	0
9.00	0	0	0	0	0
10.00	0	0	0	0	0
200.00	0	0	0	0	0

	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

	RCE Disallowance	Adjustment	
	17.00	18.00	
1.00	0	837,819	1.00
2.00	0	931,033	2.00
3.00	0	202,325	3.00
4.00	0	538,629	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	2,509,806	200.00

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
		1.00	2.00			
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	1,415,383	1,415,383			1.00
2.00	CAP REL COSTS-MVBLE EQUIP	693,895	693,895			2.00
4.00	EMPLOYEE BENEFITS	3,698,699	23,788	11,662	3,734,149	4.00
5.00	ADMINISTRATIVE & GENERAL	5,761,175	131,244	64,342	625,462	5.00
6.00	MAINTENANCE & REPAIRS	747,436	59,170	29,008	52,543	6.00
8.00	LAUNDRY & LINEN SERVICE	52,890	12,460	6,109	0	8.00
9.00	HOUSEKEEPING	271,655	12,904	6,326	0	9.00
10.00	DIETARY	870,488	69,586	34,115	71,702	10.00
11.00	CAFETERIA	0	87,977	43,131	0	11.00
13.00	NURSING ADMINISTRATION	771,143	4,953	2,428	196,946	13.00
15.00	PHARMACY	934,912	6,041	2,962	3,420	15.00
16.00	MEDICAL RECORDS & LIBRARY	462,830	23,810	11,673	75,014	16.00
17.00	SOCIAL SERVICE	510,014	29,474	14,450	132,638	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	6,311,659	477,955	234,318	1,509,055	30.00
31.00	INTENSIVE CARE UNIT	0	0	0	0	31.00
31.01	CHEMICAL DEPENDENCY	702,148	98,127	48,107	167,175	31.01
ANCILLARY SERVICE COST CENTERS						
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
57.00	CT SCAN	0	0	0	0	57.00
60.00	LABORATORY	0	0	0	0	60.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	74,081	0	0	0	70.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	0	0	0	0	90.00
90.01	OUTPATIENT	5,018,717	377,894	185,264	883,272	90.01
SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	28,297,125	1,415,383	693,895	3,717,227	118.00
NONREIMBURSABLE COST CENTERS						
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.01	COMMUNITY RELATIONS	110,486	0	0	16,922	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)	28,407,611	1,415,383	693,895	3,734,149	202.00

Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	6.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL	6,582,223					5.00
6.00	MAINTENANCE & REPAIRS	267,856	1,156,013				6.00
8.00	LAUNDRY & LINEN SERVICE	21,551	15,531	108,541			8.00
9.00	HOUSEKEEPING	87,727	16,085	0	394,697		9.00
10.00	DIETARY	315,426	86,737	0	30,447	1,478,501	10.00
11.00	CAFETERIA	39,540	109,660	0	38,494	255,697	11.00
13.00	NURSING ADMINISTRATION	294,188	6,174	0	2,167	0	13.00
15.00	PHARMACY	285,703	7,530	0	2,643	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	172,907	29,678	0	10,418	0	16.00
17.00	SOCIAL SERVICE	207,062	36,738	0	12,896	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	2,573,421	595,753	95,644	209,128	1,069,661	30.00
31.00	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
31.01	CHEMICAL DEPENDENCY	306,278	122,312	12,897	42,935	144,232	31.01
ANCILLARY SERVICE COST CENTERS							
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	CT SCAN	0	0	0	0	0	57.00
60.00	LABORATORY	0	0	0	0	0	60.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	22,342	0	0	0	0	70.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	CLINIC	0	0	0	0	0	90.00
90.01	OUTPATIENT	1,949,798	129,815	0	45,569	8,911	90.01
SPECIAL PURPOSE COST CENTERS							
113.00	INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	6,543,799	1,156,013	108,541	394,697	1,478,501	118.00
NONREIMBURSABLE COST CENTERS							
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	COMMUNITY RELATIONS	38,424	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)	6,582,223	1,156,013	108,541	394,697	1,478,501	202.00

Cost Center Description	CAFETERIA	NURSING ADMINISTRATIO N	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
	11.00	13.00	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
5.00 ADMINISTRATIVE & GENERAL						5.00
6.00 MAINTENANCE & REPAIRS						6.00
8.00 LAUNDRY & LINEN SERVICE						8.00
9.00 HOUSEKEEPING						9.00
10.00 DIETARY						10.00
11.00 CAFETERIA	574,499					11.00
13.00 NURSING ADMINISTRATION	34,159	1,312,158				13.00
15.00 PHARMACY	3,105	0	1,246,316			15.00
16.00 MEDICAL RECORDS & LIBRARY	24,843	0	0	811,173		16.00
17.00 SOCIAL SERVICE	34,159	0	0	0	977,431	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	388,177	1,156,250	0	675,977	868,828	30.00
31.00 INTENSIVE CARE UNIT	0	0	0	0	0	31.00
31.01 CHEMICAL DEPENDENCY	40,370	155,908	0	67,598	108,603	31.01
ANCILLARY SERVICE COST CENTERS						
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00 CT SCAN	0	0	0	0	0	57.00
60.00 LABORATORY	0	0	0	0	0	60.00
69.00 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	1,246,316	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 CLINIC	0	0	0	0	0	90.00
90.01 OUTPATIENT	49,686	0	0	67,598	0	90.01
SPECIAL PURPOSE COST CENTERS						
113.00 INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	574,499	1,312,158	1,246,316	811,173	977,431	118.00
NONREIMBURSABLE COST CENTERS						
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01 COMMUNITY RELATIONS	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)	574,499	1,312,158	1,246,316	811,173	977,431	202.00

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT				1.00
2.00	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	EMPLOYEE BENEFITS				4.00
5.00	ADMINISTRATIVE & GENERAL				5.00
6.00	MAINTENANCE & REPAIRS				6.00
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
15.00	PHARMACY				15.00
16.00	MEDICAL RECORDS & LIBRARY				16.00
17.00	SOCIAL SERVICE				17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS	16,165,826	0	16,165,826	30.00
31.00	INTENSIVE CARE UNIT	0	0	0	31.00
31.01	CHEMICAL DEPENDENCY	2,016,690	0	2,016,690	31.01
ANCILLARY SERVICE COST CENTERS					
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
57.00	CT SCAN	0	0	0	57.00
60.00	LABORATORY	0	0	0	60.00
69.00	ELECTROCARDIOLOGY	0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	96,423	0	96,423	70.00
73.00	DRUGS CHARGED TO PATIENTS	1,246,316	0	1,246,316	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	CLINIC	0	0	0	90.00
90.01	OUTPATIENT	8,716,524	0	8,716,524	90.01
SPECIAL PURPOSE COST CENTERS					
113.00	INTEREST EXPENSE				113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	28,241,779	0	28,241,779	118.00
NONREIMBURSABLE COST CENTERS					
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	192.00
192.01	COMMUNITY RELATIONS	165,832	0	165,832	192.01
200.00	Cross Foot Adjustments	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	28,407,611	0	28,407,611	202.00

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	23,788	11,662	35,450	35,450 4.00
5.00	ADMINISTRATIVE & GENERAL	0	131,244	64,342	195,586	5,939 5.00
6.00	MAINTENANCE & REPAIRS	0	59,170	29,008	88,178	499 6.00
8.00	LAUNDRY & LINEN SERVICE	0	12,460	6,109	18,569	0 8.00
9.00	HOUSEKEEPING	0	12,904	6,326	19,230	0 9.00
10.00	DIETARY	0	69,586	34,115	103,701	681 10.00
11.00	CAFETERIA	0	87,977	43,131	131,108	0 11.00
13.00	NURSING ADMINISTRATION	0	4,953	2,428	7,381	1,870 13.00
15.00	PHARMACY	0	6,041	2,962	9,003	32 15.00
16.00	MEDICAL RECORDS & LIBRARY	0	23,810	11,673	35,483	712 16.00
17.00	SOCIAL SERVICE	0	29,474	14,450	43,924	1,259 17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	0	477,955	234,318	712,273	14,324 30.00
31.00	INTENSIVE CARE UNIT	0	0	0	0	0 31.00
31.01	CHEMICAL DEPENDENCY	0	98,127	48,107	146,234	1,587 31.01
ANCILLARY SERVICE COST CENTERS						
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0 54.00
57.00	CT SCAN	0	0	0	0	0 57.00
60.00	LABORATORY	0	0	0	0	0 60.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0 69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0 70.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	0	0	0	0	0 90.00
90.01	OUTPATIENT	0	377,894	185,264	563,158	8,386 90.01
SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	1,415,383	693,895	2,109,278	35,289 118.00
NONREIMBURSABLE COST CENTERS						
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0 192.00
192.01	COMMUNITY RELATIONS	0	0	0	0	161 192.01
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					0 201.00
202.00	TOTAL (sum lines 118-201)	0	1,415,383	693,895	2,109,278	35,450 202.00

Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	6.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL	201,525					5.00
6.00	MAINTENANCE & REPAIRS	8,201	96,878				6.00
8.00	LAUNDRY & LINEN SERVICE	660	1,302	20,531			8.00
9.00	HOUSEKEEPING	2,686	1,348	0	23,264		9.00
10.00	DIETARY	9,658	7,269	0	1,795	123,104	10.00
11.00	CAFETERIA	1,211	9,190	0	2,269	21,290	11.00
13.00	NURSING ADMINISTRATION	9,007	517	0	128	0	13.00
15.00	PHARMACY	8,748	631	0	156	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	5,294	2,487	0	614	0	16.00
17.00	SOCIAL SERVICE	6,340	3,079	0	760	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	78,783	49,926	18,092	12,325	89,063	30.00
31.00	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
31.01	CHEMICAL DEPENDENCY	9,378	10,250	2,439	2,531	12,009	31.01
ANCILLARY SERVICE COST CENTERS							
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	CT SCAN	0	0	0	0	0	57.00
60.00	LABORATORY	0	0	0	0	0	60.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	684	0	0	0	0	70.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	CLINIC	0	0	0	0	0	90.00
90.01	OUTPATIENT	59,699	10,879	0	2,686	742	90.01
SPECIAL PURPOSE COST CENTERS							
113.00	INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	200,349	96,878	20,531	23,264	123,104	118.00
NONREIMBURSABLE COST CENTERS							
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	COMMUNITY RELATIONS	1,176	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)	201,525	96,878	20,531	23,264	123,104	202.00

Cost Center Description	CAFETERIA	NURSING ADMINISTRATIO N	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
	11.00	13.00	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
5.00 ADMINISTRATIVE & GENERAL						5.00
6.00 MAINTENANCE & REPAIRS						6.00
8.00 LAUNDRY & LINEN SERVICE						8.00
9.00 HOUSEKEEPING						9.00
10.00 DIETARY						10.00
11.00 CAFETERIA	165,068					11.00
13.00 NURSING ADMINISTRATION	9,815	28,718				13.00
15.00 PHARMACY	892	0	19,462			15.00
16.00 MEDICAL RECORDS & LIBRARY	7,138	0	0	51,728		16.00
17.00 SOCIAL SERVICE	9,815	0	0	0	65,177	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	111,533	25,306	0	43,106	57,935	30.00
31.00 INTENSIVE CARE UNIT	0	0	0	0	0	31.00
31.01 CHEMICAL DEPENDENCY	11,599	3,412	0	4,311	7,242	31.01
ANCILLARY SERVICE COST CENTERS						
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00 CT SCAN	0	0	0	0	0	57.00
60.00 LABORATORY	0	0	0	0	0	60.00
69.00 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	19,462	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 CLINIC	0	0	0	0	0	90.00
90.01 OUTPATIENT	14,276	0	0	4,311	0	90.01
SPECIAL PURPOSE COST CENTERS						
113.00 INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	165,068	28,718	19,462	51,728	65,177	118.00
NONREIMBURSABLE COST CENTERS						
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01 COMMUNITY RELATIONS	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)	165,068	28,718	19,462	51,728	65,177	202.00

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT				1.00
2.00	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	EMPLOYEE BENEFITS				4.00
5.00	ADMINISTRATIVE & GENERAL				5.00
6.00	MAINTENANCE & REPAIRS				6.00
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
15.00	PHARMACY				15.00
16.00	MEDICAL RECORDS & LIBRARY				16.00
17.00	SOCIAL SERVICE				17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS	1,212,666	0	1,212,666	30.00
31.00	INTENSIVE CARE UNIT	0	0	0	31.00
31.01	CHEMICAL DEPENDENCY	210,992	0	210,992	31.01
ANCILLARY SERVICE COST CENTERS					
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
57.00	CT SCAN	0	0	0	57.00
60.00	LABORATORY	0	0	0	60.00
69.00	ELECTROCARDIOLOGY	0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	684	0	684	70.00
73.00	DRUGS CHARGED TO PATIENTS	19,462	0	19,462	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	CLINIC	0	0	0	90.00
90.01	OUTPATIENT	664,137	0	664,137	90.01
SPECIAL PURPOSE COST CENTERS					
113.00	INTEREST EXPENSE				113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	2,107,941	0	2,107,941	118.00
NONREIMBURSABLE COST CENTERS					
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	192.00
192.01	COMMUNITY RELATIONS	1,337	0	1,337	192.01
200.00	Cross Foot Adjustments	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	2,109,278	0	2,109,278	202.00

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCU. COST)	
	BLDG & FIXT (SQ. FEET)	MVBLE EQUIP (SQ. FEET)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	63,725				1.00
2.00	CAP REL COSTS-MVBLE EQUIP		63,725			2.00
4.00	EMPLOYEE BENEFITS	1,071	1,071	14,267,426		4.00
5.00	ADMINISTRATIVE & GENERAL	5,909	5,909	2,389,767	-6,582,223	5.00
6.00	MAINTENANCE & REPAIRS	2,664	2,664	200,756	0	6.00
8.00	LAUNDRY & LINEN SERVICE	561	561	0	0	8.00
9.00	HOUSEKEEPING	581	581	0	0	9.00
10.00	DIETARY	3,133	3,133	273,959	0	10.00
11.00	CAFETERIA	3,961	3,961	0	0	11.00
13.00	NURSING ADMINISTRATION	223	223	752,492	0	13.00
15.00	PHARMACY	272	272	13,066	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	1,072	1,072	286,612	0	16.00
17.00	SOCIAL SERVICE	1,327	1,327	506,785	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	21,519	21,519	5,765,781	0	30.00
31.00	INTENSIVE CARE UNIT	0	0	0	0	31.00
31.01	CHEMICAL DEPENDENCY	4,418	4,418	638,744	0	31.01
ANCILLARY SERVICE COST CENTERS						
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
57.00	CT SCAN	0	0	0	0	57.00
60.00	LABORATORY	0	0	0	0	60.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	0	0	0	0	90.00
90.01	OUTPATIENT	17,014	17,014	3,374,809	0	90.01
SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	63,725	63,725	14,202,771	-6,582,223	118.00
NONREIMBURSABLE COST CENTERS						
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.01	COMMUNITY RELATIONS	0	0	64,655	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)	1,415,383	693,895	3,734,149		202.00
203.00	Unit cost multiplier (wkst. B, Part I)	22.210796	10.888898	0.261725		203.00
204.00	Cost to be allocated (per wkst. B, Part II)			35,450		204.00
205.00	Unit cost multiplier (wkst. B, Part II)			0.002485		205.00

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (PAID FTE'S)	
		6.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
6.00	MAINTENANCE & REPAIRS	41,756					6.00
8.00	LAUNDRY & LINEN SERVICE	561	28,834				8.00
9.00	HOUSEKEEPING	581	0	40,614			9.00
10.00	DIETARY	3,133	0	3,133	105,358		10.00
11.00	CAFETERIA	3,961	0	3,961	18,221	185	11.00
13.00	NURSING ADMINISTRATION	223	0	223	0	11	13.00
15.00	PHARMACY	272	0	272	0	1	15.00
16.00	MEDICAL RECORDS & LIBRARY	1,072	0	1,072	0	8	16.00
17.00	SOCIAL SERVICE	1,327	0	1,327	0	11	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	21,519	25,408	21,519	76,224	125	30.00
31.00	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
31.01	CHEMICAL DEPENDENCY	4,418	3,426	4,418	10,278	13	31.01
ANCILLARY SERVICE COST CENTERS							
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	CT SCAN	0	0	0	0	0	57.00
60.00	LABORATORY	0	0	0	0	0	60.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	CLINIC	0	0	0	0	0	90.00
90.01	OUTPATIENT	4,689	0	4,689	635	16	90.01
SPECIAL PURPOSE COST CENTERS							
113.00	INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	41,756	28,834	40,614	105,358	185	118.00
NONREIMBURSABLE COST CENTERS							
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	COMMUNITY RELATIONS	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)	1,156,013	108,541	394,697	1,478,501	574,499	202.00
203.00	Unit cost multiplier (wkst. B, Part I)	27.684955	3.764341	9.718250	14.033116	3,105.400000	203.00
204.00	Cost to be allocated (per wkst. B, Part II)	96,878	20,531	23,264	123,104	165,068	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	2.320098	0.712041	0.572807	1.168435	892.259459	205.00

Cost Center Description		NURSING ADMINISTRATIO N (PATIENT DAYS)	PHARMACY (PCT. OF UTILZ)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	
		13.00	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
5.00	ADMINISTRATIVE & GENERAL					5.00
6.00	MAINTENANCE & REPAIRS					6.00
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	28,834				13.00
15.00	PHARMACY	0	100			15.00
16.00	MEDICAL RECORDS & LIBRARY	0	0	12		16.00
17.00	SOCIAL SERVICE	0	0	0	90	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	25,408	0	10	80	30.00
31.00	INTENSIVE CARE UNIT	0	0	0	0	31.00
31.01	CHEMICAL DEPENDENCY	3,426	0	1	10	31.01
ANCILLARY SERVICE COST CENTERS						
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
57.00	CT SCAN	0	0	0	0	57.00
60.00	LABORATORY	0	0	0	0	60.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
73.00	DRUGS CHARGED TO PATIENTS	0	100	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	0	0	0	0	90.00
90.01	OUTPATIENT	0	0	1	0	90.01
SPECIAL PURPOSE COST CENTERS						
113.00	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	28,834	100	12	90	118.00
NONREIMBURSABLE COST CENTERS						
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.01	COMMUNITY RELATIONS	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)	1,312,158	1,246,316	811,173	977,431	202.00
203.00	Unit cost multiplier (wkst. B, Part I)	45.507318	12,463.160000	67,597.750000	10,860.344444	203.00
204.00	Cost to be allocated (per wkst. B, Part II)	28,718	19,462	51,728	65,177	204.00
205.00	Unit cost multiplier (wkst. B, Part II)	0.995977	194.620000	4,310.666667	724.188889	205.00

Title XVIII

Hospital

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	16,165,826		16,165,826	0	16,165,826	30.00
31.00 INTENSIVE CARE UNIT	0		0	0	0	31.00
31.01 CHEMICAL DEPENDENCY	2,016,690		2,016,690	0	2,016,690	31.01
ANCILLARY SERVICE COST CENTERS						
54.00 RADIOLOGY-DIAGNOSTIC	0		0	0	0	54.00
57.00 CT SCAN	0		0	0	0	57.00
60.00 LABORATORY	0		0	0	0	60.00
69.00 ELECTROCARDIOLOGY	0		0	0	0	69.00
70.00 ELECTROENCEPHALOGRAPHY	96,423		96,423	0	96,423	70.00
73.00 DRUGS CHARGED TO PATIENTS	1,246,316		1,246,316	0	1,246,316	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 CLINIC	0		0	0	0	90.00
90.01 OUTPATIENT	8,716,524		8,716,524	0	8,716,524	90.01
SPECIAL PURPOSE COST CENTERS						
113.00 INTEREST EXPENSE						113.00
200.00 Subtotal (see instructions)	28,241,779	0	28,241,779	0	28,241,779	200.00
201.00 Less Observation Beds	0		0		0	201.00
202.00 Total (see instructions)	28,241,779	0	28,241,779	0	28,241,779	202.00

Title XVIII

Hospital

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	22,809,859		22,809,859			30.00
31.00 INTENSIVE CARE UNIT	0		0			31.00
31.01 CHEMICAL DEPENDENCY	1,885,400		1,885,400			31.01
ANCILLARY SERVICE COST CENTERS						
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	0.000000	0.000000	54.00
57.00 CT SCAN	0	0	0	0.000000	0.000000	57.00
60.00 LABORATORY	0	0	0	0.000000	0.000000	60.00
69.00 ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
70.00 ELECTROENCEPHALOGRAPHY	168,226	0	168,226	0.573175	0.000000	70.00
73.00 DRUGS CHARGED TO PATIENTS	2,070,956	6,540	2,077,496	0.599913	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 CLINIC	0	0	0	0.000000	0.000000	90.00
90.01 OUTPATIENT	0	30,585,080	30,585,080	0.284993	0.000000	90.01
SPECIAL PURPOSE COST CENTERS						
113.00 INTEREST EXPENSE						113.00
200.00 Subtotal (see instructions)	26,934,441	30,591,620	57,526,061			200.00
201.00 Less observation Beds						201.00
202.00 Total (see instructions)	26,934,441	30,591,620	57,526,061			202.00

Cost Center Description		PPS Inpatient Ratio	
		11.00	
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS		30.00
31.00	INTENSIVE CARE UNIT		31.00
31.01	CHEMICAL DEPENDENCY		31.01
ANCILLARY SERVICE COST CENTERS			
54.00	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
57.00	CT SCAN	0.000000	57.00
60.00	LABORATORY	0.000000	60.00
69.00	ELECTROCARDIOLOGY	0.000000	69.00
70.00	ELECTROENCEPHALOGRAPHY	0.573175	70.00
73.00	DRUGS CHARGED TO PATIENTS	0.599913	73.00
OUTPATIENT SERVICE COST CENTERS			
90.00	CLINIC	0.000000	90.00
90.01	OUTPATIENT	0.284993	90.01
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

Provider CCN: 264012

Period:
 From 01/01/2011
 To 12/31/2011

Worksheet C
 Part I
 Date/Time Prepared:
 5/29/2012 1:24 pm

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	16,165,826		16,165,826	0	0	30.00
31.00 INTENSIVE CARE UNIT	0		0	0	0	31.00
31.01 CHEMICAL DEPENDENCY	2,016,690		2,016,690	0	0	31.01
ANCILLARY SERVICE COST CENTERS						
54.00 RADIOLOGY-DIAGNOSTIC	0		0	0	0	54.00
57.00 CT SCAN	0		0	0	0	57.00
60.00 LABORATORY	0		0	0	0	60.00
69.00 ELECTROCARDIOLOGY	0		0	0	0	69.00
70.00 ELECTROENCEPHALOGRAPHY	96,423		96,423	0	0	70.00
73.00 DRUGS CHARGED TO PATIENTS	1,246,316		1,246,316	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 CLINIC	0		0	0	0	90.00
90.01 OUTPATIENT	8,716,524		8,716,524	0	0	90.01
SPECIAL PURPOSE COST CENTERS						
113.00 INTEREST EXPENSE						113.00
200.00 Subtotal (see instructions)	28,241,779	0	28,241,779	0	0	200.00
201.00 Less Observation Beds	0		0			201.00
202.00 Total (see instructions)	28,241,779	0	28,241,779	0	0	202.00

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	22,809,859		22,809,859		30.00
31.00 INTENSIVE CARE UNIT	0		0		31.00
31.01 CHEMICAL DEPENDENCY	1,885,400		1,885,400		31.01
ANCILLARY SERVICE COST CENTERS					
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	0.000000	54.00
57.00 CT SCAN	0	0	0	0.000000	57.00
60.00 LABORATORY	0	0	0	0.000000	60.00
69.00 ELECTROCARDIOLOGY	0	0	0	0.000000	69.00
70.00 ELECTROENCEPHALOGRAPHY	168,226	0	168,226	0.573175	70.00
73.00 DRUGS CHARGED TO PATIENTS	2,070,956	6,540	2,077,496	0.599913	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00 CLINIC	0	0	0	0.000000	90.00
90.01 OUTPATIENT	0	30,585,080	30,585,080	0.284993	90.01
SPECIAL PURPOSE COST CENTERS					
113.00 INTEREST EXPENSE					113.00
200.00 Subtotal (see instructions)	26,934,441	30,591,620	57,526,061		200.00
201.00 Less Observation Beds					201.00
202.00 Total (see instructions)	26,934,441	30,591,620	57,526,061		202.00

Provider CCN: 264012

Period:
 From 01/01/2011
 To 12/31/2011

Worksheet C
 Part I
 Date/Time Prepared:
 5/29/2012 1:24 pm

Title XIX

Hospital

Cost

Cost Center Description		PPS Inpatient Ratio	
		11.00	
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS		30.00
31.00	INTENSIVE CARE UNIT		31.00
31.01	CHEMICAL DEPENDENCY		31.01
ANCILLARY SERVICE COST CENTERS			
54.00	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
57.00	CT SCAN	0.000000	57.00
60.00	LABORATORY	0.000000	60.00
69.00	ELECTROCARDIOLOGY	0.000000	69.00
70.00	ELECTROENCEPHALOGRAPHY	0.000000	70.00
73.00	DRUGS CHARGED TO PATIENTS	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS			
90.00	CLINIC	0.000000	90.00
90.01	OUTPATIENT	0.000000	90.01
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

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	1,212,666	0	1,212,666	25,408	47.73	30.00
31.00	INTENSIVE CARE UNIT	0		0	0	0.00	31.00
31.01	CHEMICAL DEPENDENCY	210,992		210,992	3,426	61.59	31.01
200.00	Total (lines 30-199)	1,423,658		1,423,658	28,834		200.00

Title XVIII

Hospital

Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	6,424	306,618	30.00
31.00	INTENSIVE CARE UNIT	0	0	31.00
31.01	CHEMICAL DEPENDENCY	0	0	31.01
200.00	Total (lines 30-199)	6,424	306,618	200.00

Cost Center Description		Title XVIII			Hospital	PPS
		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						
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0.000000	0	0
57.00	CT SCAN	0	0	0.000000	0	0
60.00	LABORATORY	0	0	0.000000	0	0
69.00	ELECTROCARDIOLOGY	0	0	0.000000	0	0
70.00	ELECTROENCEPHALOGRAPHY	684	168,226	0.004066	145,162	590
73.00	DRUGS CHARGED TO PATIENTS	19,462	2,077,496	0.009368	878,639	8,231
OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	0	0	0.000000	0	0
90.01	OUTPATIENT	664,137	30,585,080	0.021714	0	0
200.00	Total (lines 50-199)	684,283	32,830,802		1,023,801	8,821

Cost Center Description		Title XVIII				Hospital	Total Costs (sum of cols. 1 through 3, minus col. 4)
		Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	PPS	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	0	0	0	0	0	0 30.00
31.00	INTENSIVE CARE UNIT	0	0	0	0	0	0 31.00
31.01	CHEMICAL DEPENDENCY	0	0	0	0	0	0 31.01
200.00	Total (lines 30-199)	0	0	0	0	0	0 200.00

Cost Center Description	Total Patient Days	Per Diem (col. 5 + col. 6)	Inpatient Program Days	Hospital PPS	
				Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. Nursing School
	6.00	7.00	8.00	9.00	11.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 ADULTS & PEDIATRICS	25,408	0.00	6,424	0	0
31.00 INTENSIVE CARE UNIT	0	0.00	0	0	0
31.01 CHEMICAL DEPENDENCY	3,426	0.00	0	0	0
200.00 Total (lines 30-199)	28,834		6,424	0	0

Title XVIII

Hospital

PPS

Cost Center Description		PSA Adj. Allied Health Cost	PSA Adj. All Other Medical Education Cost	
		12.00	13.00	
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	0	0	30.00
31.00	INTENSIVE CARE UNIT	0	0	31.00
31.01	CHEMICAL DEPENDENCY	0	0	31.01
200.00	Total (lines 30-199)	0	0	200.00

Health Financial Systems
 APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
 THROUGH COSTS

CENTERPOINTE HOSPITAL

Provider CCN: 264012

Period:
 From 01/01/2011
 To 12/31/2011

In Lieu of Form CMS-2552-10
 Worksheet D
 Part IV
 Date/Time Prepared:
 5/29/2012 1:24 pm
 PPS

Title XVIII

Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)
	1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS					
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0 54.00
57.00 CT SCAN	0	0	0	0	0 57.00
60.00 LABORATORY	0	0	0	0	0 60.00
69.00 ELECTROCARDIOLOGY	0	0	0	0	0 69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0	0 70.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
OUTPATIENT SERVICE COST CENTERS					
90.00 CLINIC	0	0	0	0	0 90.00
90.01 OUTPATIENT	0	0	0	0	0 90.01
200.00 Total (lines 50-199)	0	0	0	0	0 200.00

Cost Center Description		Title XVIII			Hospital	
		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges PPS
		6.00	7.00	8.00	9.00	10.00
ANCILLARY SERVICE COST CENTERS						
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0.000000	0.000000	0
57.00	CT SCAN	0	0	0.000000	0.000000	0
60.00	LABORATORY	0	0	0.000000	0.000000	0
69.00	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0
70.00	ELECTROENCEPHALOGRAPHY	0	168,226	0.000000	0.000000	145,162
73.00	DRUGS CHARGED TO PATIENTS	0	2,077,496	0.000000	0.000000	878,639
OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	0	0	0.000000	0.000000	0
90.01	OUTPATIENT	0	30,585,080	0.000000	0.000000	0
200.00	Total (lines 50-199)	0	32,830,802			1,023,801

Title XVIII

Hospital

PPS

Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
	11.00	12.00	13.00	21.00	22.00	
ANCILLARY SERVICE COST CENTERS						
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0 54.00
57.00 CT SCAN	0	0	0	0	0	0 57.00
60.00 LABORATORY	0	0	0	0	0	0 60.00
69.00 ELECTROCARDIOLOGY	0	0	0	0	0	0 69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	0 70.00
73.00 DRUGS CHARGED TO PATIENTS	0	228	0	0	0	0 73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 CLINIC	0	0	0	0	0	0 90.00
90.01 OUTPATIENT	0	15,761,027	0	0	0	0 90.01
200.00 Total (lines 50-199)	0	15,761,255	0	0	0	0 200.00

Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	
		23.00	24.00	
ANCILLARY SERVICE COST CENTERS				
54.00	RADIOLOGY-DIAGNOSTIC	0	0	54.00
57.00	CT SCAN	0	0	57.00
60.00	LABORATORY	0	0	60.00
69.00	ELECTROCARDIOLOGY	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	70.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	73.00
OUTPATIENT SERVICE COST CENTERS				
90.00	CLINIC	0	0	90.00
90.01	OUTPATIENT	0	0	90.01
200.00	Total (lines 50-199)	0	0	200.00

Title XVIII

Hospital

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	3.00	4.00	
ANCILLARY SERVICE COST CENTERS					
54.00 RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	54.00
57.00 CT SCAN	0.000000	0	0	0	57.00
60.00 LABORATORY	0.000000	0	0	0	60.00
69.00 ELECTROCARDIOLOGY	0.000000	0	0	0	69.00
70.00 ELECTROENCEPHALOGRAPHY	0.573175	0	0	0	70.00
73.00 DRUGS CHARGED TO PATIENTS	0.599913	228	0	0	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00 CLINIC	0.000000	0	0	0	90.00
90.01 OUTPATIENT	0.284993	15,761,027	0	0	90.01
200.00 Subtotal (see instructions)		15,761,255	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)		15,761,255	0	0	202.00

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					
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
57.00	CT SCAN	0	0	0	57.00
60.00	LABORATORY	0	0	0	60.00
69.00	ELECTROCARDIOLOGY	0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
73.00	DRUGS CHARGED TO PATIENTS	137	0	0	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	CLINIC	0	0	0	90.00
90.01	OUTPATIENT	4,491,782	0	0	90.01
200.00	Subtotal (see instructions)	4,491,919	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)	4,491,919	0	0	202.00

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)	25,408	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	25,408	2.00
3.00	Private room days (excluding swing-bed and observation bed days)	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	25,408	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)	6,424	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
SWING BED ADJUSTMENT			
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	16,165,826	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)	16,165,826	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28.00	General inpatient routine service charges (excluding swing-bed charges)	22,309,375	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	22,309,375	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.724620	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)	878.05	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)	16,165,826	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)	636.25	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	4,087,270	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)	4,087,270	41.00

Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
43.01 CHEMICAL DEPENDENCY	2,016,690	3,426	588.64	0	0	43.01
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)					610,310	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					4,697,580	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)					306,618	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					8,821	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					315,439	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					4,382,141	53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00 Program discharges					0	54.00
55.00 Target amount per discharge					0.00	55.00
56.00 Target amount (line 54 x line 55)					0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00 Bonus payment (see instructions)					0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00 Relief payment (see instructions)					0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY						
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)						70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2)						71.00
72.00 Program routine service cost (line 9 x line 71)						72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from worksheet B, Part II, column 26, line 45)						75.00
76.00 Per diem capital-related costs (line 75 + line 2)						76.00
77.00 Program capital-related costs (line 9 x line 76)						77.00
78.00 Inpatient routine service cost (line 74 minus line 77)						78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00 Inpatient routine service cost per diem limitation						81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00 Reasonable inpatient routine service costs (see instructions)						83.00
84.00 Program inpatient ancillary services (see instructions)						84.00
85.00 Utilization review - physician compensation (see instructions)						85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00 Total observation bed days (see instructions)					0	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

Cost Center Description	Title XVIII Hospital PPS				
	Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)
	1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
90.00 Capital-related cost	1,212,666	16,165,826	0.075014	0	0 90.00
91.00 Nursing School cost	0	16,165,826	0.000000	0	0 91.00
92.00 Allied health cost	0	16,165,826	0.000000	0	0 92.00
93.00 All other Medical Education	0	16,165,826	0.000000	0	0 93.00

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)	25,408	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	25,408	2.00
3.00	Private room days (excluding swing-bed and observation bed days)	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	25,408	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)	7,101	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
SWING BED ADJUSTMENT			
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	16,165,826	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)	16,165,826	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28.00	General inpatient routine service charges (excluding swing-bed charges)	22,309,375	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	22,309,375	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.724620	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)	878.05	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)	16,165,826	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)	636.25	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	4,518,011	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	4,518,011	41.00

Title XIX Hospital Cost

Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
42.00 NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00	42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
43.01 CHEMICAL DEPENDENCY	2,016,690	3,426	588.64	0	0	43.01
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)					163,787	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					4,681,798	49.00
PASS THROUGH COST ADJUSTMENTS						
50.00 Pass through costs applicable to Program inpatient routine services (from wkst. D, sum of Parts I and III)					0	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from wkst. D, sum of Parts II and IV)					0	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00 Program discharges					0	54.00
55.00 Target amount per discharge					0.00	55.00
56.00 Target amount (line 54 x line 55)					0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00 Bonus payment (see instructions)					0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00 Relief payment (see instructions)					0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY						
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)						70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00 Program routine service cost (line 9 x line 71)						72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from worksheet B, Part II, column 26, line 45)						75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00 Program capital-related costs (line 9 x line 76)						77.00
78.00 Inpatient routine service cost (line 74 minus line 77)						78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00 Inpatient routine service cost per diem limitation						81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00 Reasonable inpatient routine service costs (see instructions)						83.00
84.00 Program inpatient ancillary services (see instructions)						84.00
85.00 Utilization review - physician compensation (see instructions)						85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00 Total observation bed days (see instructions)					0	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00 observation bed cost (line 87 x line 88) (see instructions)					0	89.00

Cost Center Description	Title XIX		Hospital		Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
	Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)		
	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

Provider CCN: 264012

Period:
 From 01/01/2011
 To 12/31/2011

Date/Time Prepared:
 5/29/2012 1:24 pm

Title XVIII

Hospital

PPS

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		5,858,978		30.00
31.00	INTENSIVE CARE UNIT		0		31.00
31.01	CHEMICAL DEPENDENCY		0		31.01
ANCILLARY SERVICE COST CENTERS					
54.00	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	54.00
57.00	CT SCAN	0.000000	0	0	57.00
60.00	LABORATORY	0.000000	0	0	60.00
69.00	ELECTROCARDIOLOGY	0.000000	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY.	0.573175	145,162	83,203	70.00
73.00	DRUGS CHARGED TO PATIENTS	0.599913	878,639	527,107	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	CLINIC	0.000000	0	0	90.00
90.01	OUTPATIENT	0.284993	0	0	90.01
200.00	Total (sum of lines 50-94 and 96-98)		1,023,801	610,310	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		1,023,801		202.00

Provider CCN: 264012

Period:
 From 01/01/2011
 To 12/31/2011

Worksheet D-3

Date/Time Prepared:
 5/29/2012 1:24 pm

Title XIX

Hospital

Cost

Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS		5,939,181		30.00
31.00	INTENSIVE CARE UNIT		0		31.00
31.01	CHEMICAL DEPENDENCY		0		31.01
ANCILLARY SERVICE COST CENTERS					
54.00	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	54.00
57.00	CT SCAN	0.000000	0	0	57.00
60.00	LABORATORY	0.000000	0	0	60.00
69.00	ELECTROCARDIOLOGY	0.000000	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0.573175	0	0	70.00
73.00	DRUGS CHARGED TO PATIENTS	0.599913	273,018	163,787	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	CLINIC	0.000000	0	0	90.00
90.01	OUTPATIENT	0.284993	0	0	90.01
200.00	Total (sum of lines 50-94 and 96-98)		273,018	163,787	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)		273,018		202.00

Provider CCN: 264012

Period:
 From 01/01/2011
 To 12/31/2011

Worksheet E
 Part B
 Date/Time Prepared:
 5/29/2012 1:24 pm
 PPS

Title XVIII

Hospital

		1.00	
PART B - MEDICAL AND OTHER HEALTH SERVICES			
1.00	Medical and other services (see instructions)	0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	4,491,919	2.00
3.00	PPS payments	4,813,051	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from worksheet D, Part IV, column 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	0	11.00
COMPUTATION OF LESSER OF COST OR CHARGES			
Reasonable charges			
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from worksheet D-4, Part III, line 69, col. 4)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
Customary charges			
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	0	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	4,813,051	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
25.00	Deductibles and coinsurance (for CAH, see instructions)	1,027,359	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	0	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)	3,785,692	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)	3,785,692	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	3,785,692	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)	140,616	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	98,431	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)	3,884,123	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)	3,884,123	40.00
41.00	Interim payments	3,781,936	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)	102,187	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	44.00
TO BE COMPLETED BY CONTRACTOR			
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

Provider CCN: 264012

Period:
From 01/01/2011
To 12/31/2011

Worksheet E
Part B
Date/Time Prepared:
5/29/2012 1:24 pm
PPS

Title XVIII

Hospital

Overrides
1.00

WORKSHEET OVERRIDE VALUES

112.00	override of Ancillary service charges (line 12)	0	112.00
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		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		3,670,047		3,772,316	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	12/31/2011	91,800	12/31/2011	9,620	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		91,800		9,620	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)		3,761,847		3,781,936	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		107,133		102,187	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		3,868,980		3,884,123	7.00
				Contractor Number	Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

		1.00	
PART II - MEDICARE PART A SERVICES - IPF PPS			
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	4,197,237	1.00
2.00	Net IPF PPS Outlier Payments	64,756	2.00
3.00	Net IPF PPS ECT Payments	13,777	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)	0.00	4.00
5.00	New Teaching program adjustment. (see instructions)	0.00	5.00
6.00	Current year's unweighted FTE count of I&R other than FTEs in the first 3 years of a "new teaching program". (see inst.)	0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the first 3 years of a "new teaching program". (see inst.)	0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00	8.00
9.00	Average Daily Census (see instructions)	69.610959	9.00
10.00	Medical Education Adjustment Factor $\{((1 + (\text{line 8}/\text{line 9})) \text{ raised to the power of } .5150 - 1)\}$.	0.000000	10.00
11.00	Medical Education Adjustment (line 1 multiplied by line 10).	0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	4,275,770	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)	0	13.00
14.00	Organ acquisition	0	14.00
15.00	Cost of teaching physicians (from worksheet D-5, Part II, column 3, line 20) (see instructions)	0	15.00
16.00	Subtotal (see instructions)	4,275,770	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	4,275,770	18.00
19.00	Deductibles	312,765	19.00
20.00	Subtotal (line 18 minus line 19)	3,963,005	20.00
21.00	Coinsurance	224,662	21.00
22.00	Subtotal (line 20 minus line 21)	3,738,343	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	186,624	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	130,637	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	25.00
26.00	Subtotal (sum of lines 22 and 24)	3,868,980	26.00
27.00	Direct graduate medical education payments (from worksheet E-4, line 49)	0	27.00
28.00	Other pass through costs (see instructions)	0	28.00
29.00	Outlier payments reconciliation	0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.00
30.99	Recovery of Accelerated Depreciation	0	30.99
31.00	Total amount payable to the provider (see instructions)	3,868,980	31.00
32.00	Interim payments	3,761,847	32.00
33.00	Tentative settlement (for contractor use only)	0	33.00
34.00	Balance due provider/program (line 31 minus the sum lines 32 and 33)	107,133	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	35.00
TO BE COMPLETED BY CONTRACTOR			
50.00	Original outlier amount from worksheet E-3, Part II, line 2	0	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

		1.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	4,681,798	1.00
2.00	Medical and other services	0	2.00
3.00	Organ acquisition (certified transplant centers only)	0	3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	4,681,798	4.00
5.00	Inpatient primary payer payments	0	5.00
6.00	Outpatient primary payer payments	0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	4,681,798	7.00
COMPUTATION OF LESSER OF COST OR CHARGES			
Reasonable Charges			
8.00	Routine service charges	5,939,181	8.00
9.00	Ancillary service charges	273,018	9.00
10.00	Organ acquisition charges, net of revenue	0	10.00
11.00	Incentive from target amount computation	0	11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	6,212,199	12.00
CUSTOMARY CHRGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	15.00
16.00	Total customary charges (see instructions)	6,212,199	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	1,530,401	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	18.00
19.00	Interns and Residents (see instructions)	0	19.00
20.00	Cost of Teaching Physicians (see instructions)	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	4,681,798	21.00
PROSPECTIVE PAYMENT AMOUNT			
22.00	Other than outlier payments	0	22.00
23.00	Outlier payments	0	23.00
24.00	Program capital payments	0	24.00
25.00	Capital exception payments (see instructions)	0	25.00
26.00	Routine and Ancillary service other pass through costs	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	27.00
28.00	Customary charges (title v or XIX PPS covered services only)	0	28.00
29.00	Titles V or XIX enter the sum of lines 27 and 21.	4,681,798	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	4,681,798	31.00
32.00	Deductibles	0	32.00
33.00	Coinsurance	0	33.00
34.00	Allowable bad debts (see instructions)	0	34.00
35.00	Utilization review	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	4,681,798	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	37.00
38.00	Subtotal (line 36 ± line 37)	4,681,798	38.00
39.00	Direct graduate medical education payments (from wkst. E-4)	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	4,681,798	40.00
41.00	Interim payments	3,338,721	41.00
42.00	Balance due provider/program (line 40 minus 41)	1,343,077	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2	0	43.00

	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	-582,748	0	0	0
2.00	Temporary investments	0	0	0	0
3.00	Notes receivable	0	0	0	0
4.00	Accounts receivable	8,830,730	0	0	0
5.00	Other receivable	216,331	0	0	0
6.00	Allowances for uncollectible notes and accounts receivable	-2,184,224	0	0	0
7.00	Inventory	0	0	0	0
8.00	Prepaid expenses	127,950	0	0	0
9.00	Other current assets	127,727	0	0	0
10.00	Due from other funds	0	0	0	0
11.00	Total current assets (sum of lines 1-10)	6,535,766	0	0	0
FIXED ASSETS					
12.00	Land	0	0	0	0
13.00	Land improvements	0	0	0	0
14.00	Accumulated depreciation	0	0	0	0
15.00	Buildings	0	0	0	0
16.00	Accumulated depreciation	0	0	0	0
17.00	Leasehold improvements	826,180	0	0	0
18.00	Accumulated depreciation	-250,155	0	0	0
19.00	Fixed equipment	3,041,230	0	0	0
20.00	Accumulated depreciation	-1,700,514	0	0	0
21.00	Automobiles and trucks	392,516	0	0	0
22.00	Accumulated depreciation	-367,697	0	0	0
23.00	Major movable equipment	0	0	0	0
24.00	Accumulated depreciation	0	0	0	0
25.00	Minor equipment depreciable	0	0	0	0
26.00	Accumulated depreciation	0	0	0	0
27.00	HIT designated Assets	0	0	0	0
28.00	Accumulated depreciation	0	0	0	0
29.00	Minor equipment-nondepreciable	0	0	0	0
30.00	Total fixed assets (sum of lines 12-29)	1,941,560	0	0	0
OTHER ASSETS					
31.00	Investments	200,000	0	0	0
32.00	Deposits on leases	0	0	0	0
33.00	Due from owners/officers	0	0	0	0
34.00	Other assets	36,761	0	0	0
35.00	Total other assets (sum of lines 31-34)	236,761	0	0	0
36.00	Total assets (sum of lines 11, 30, and 35)	8,714,087	0	0	0
CURRENT LIABILITIES					
37.00	Accounts payable	701,476	0	0	0
38.00	Salaries, wages, and fees payable	419,732	0	0	0
39.00	Payroll taxes payable	214,855	0	0	0
40.00	Notes and loans payable (short term)	0	0	0	0
41.00	Deferred income	0	0	0	0
42.00	Accelerated payments	0	0	0	0
43.00	Due to other funds	0	0	0	0
44.00	Other current liabilities	630,528	0	0	0
45.00	Total current liabilities (sum of lines 37 thru 44)	1,966,591	0	0	0
LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0
47.00	Notes payable	0	0	0	0
48.00	Unsecured loans	0	0	0	0
49.00	Other long term liabilities	741,443	0	0	0
50.00	Total long term liabilities (sum of lines 46 thru 49)	741,443	0	0	0
51.00	Total liabilities (sum of lines 45 and 50)	2,708,034	0	0	0
CAPITAL ACCOUNTS					
52.00	General fund balance	6,006,053	0	0	0
53.00	Specific purpose fund	0	0	0	0
54.00	Donor created - endowment fund balance - restricted	0	0	0	0
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0
56.00	Governing body created - endowment fund balance	0	0	0	0
57.00	Plant fund balance - invested in plant	0	0	0	0
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0
59.00	Total fund balances (sum of lines 52 thru 58)	6,006,053	0	0	0
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	8,714,087	0	0	0

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES

CENTERPOINTE HOSPITAL

In Lieu of Form CMS-2552-10

Provider CCN: 264012

Period:
From 01/01/2011
To 12/31/2011

Worksheet G-1

Date/Time Prepared:
5/29/2012 1:24 pm

	General Fund		Special Purpose Fund		
	1.00	2.00	3.00	4.00	
1.00 Fund balances at beginning of period		6,615,459		0	1.00
2.00 Net income (loss) (from wkst. G-3, line 29)		-344,012			2.00
3.00 Total (sum of line 1 and line 2)		6,271,447		0	3.00
4.00 Additions (credit adjustments) (specify)	0		0		4.00
5.00	0		0		5.00
6.00	0		0		6.00
7.00	0		0		7.00
8.00	0		0		8.00
9.00	0		0		9.00
10.00 Total additions (sum of line 4-9)		0		0	10.00
11.00 Subtotal (line 3 plus line 10)		6,271,447		0	11.00
12.00 Deductions (debit adjustments) (specify)	0		0		12.00
13.00 CHANGE IN PARTNERS CAPITAL	116,851		0		13.00
14.00 CHANGE IN PAID IN CAPITAL	27,500		0		14.00
15.00 CHANGE IN RETAINED EARNINGS	121,043		0		15.00
16.00	0		0		16.00
17.00	0		0		17.00
18.00 Total deductions (sum of lines 12-17)		265,394		0	18.00
19.00 Fund balance at end of period per balance sheet (line 11 minus line 18)		6,006,053		0	19.00

	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	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 CHANGE IN PARTNERS CAPITAL	0		0		13.00
14.00 CHANGE IN PAID IN CAPITAL	0		0		14.00
15.00 CHANGE IN RETAINED EARNINGS	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

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital				
2.00	SUBPROVIDER - IPF	22,309,375		22,309,375	1.00
3.00	SUBPROVIDER - IRF				2.00
4.00	SUBPROVIDER				3.00
5.00	Swing bed - SNF				4.00
6.00	Swing bed - NF	0		0	5.00
7.00	SKILLED NURSING FACILITY	0		0	6.00
8.00	NURSING FACILITY				7.00
9.00	OTHER LONG TERM CARE				8.00
10.00	Total general inpatient care services (sum of lines 1-9)	22,309,375		22,309,375	9.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	0		0	10.00
11.01	CHEMICAL DEPENDENCY	1,885,400		1,885,400	11.00
12.00	CORONARY CARE UNIT				11.01
13.00	BURN INTENSIVE CARE UNIT				12.00
14.00	SURGICAL INTENSIVE CARE UNIT				13.00
15.00	OTHER SPECIAL CARE (SPECIFY)				14.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	1,885,400		1,885,400	15.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	24,194,775		24,194,775	16.00
18.00	Ancillary services	2,827,413		2,827,413	17.00
19.00	Outpatient services	0	31,506,615	31,506,615	18.00
20.00	RURAL HEALTH CLINIC	0	0	0	19.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	20.00
22.00	HOME HEALTH AGENCY	0	0	0	21.00
23.00	AMBULANCE SERVICES				22.00
24.00	CMHC				23.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				24.00
26.00	HOSPICE				25.00
27.00	OTHER (SPECIFY)				26.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to wkst. G-3, line 1)	27,022,188	31,506,615	58,528,803	27.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per wkst. A, column 3, line 200)		31,296,504		28.00
30.00	ADD (SPECIFY)	0			29.00
31.00		0			30.00
32.00		0			31.00
33.00		0			32.00
34.00		0			33.00
35.00		0			34.00
36.00	Total additions (sum of lines 30-35)	0			35.00
37.00	DEDUCT (SPECIFY)	0	0		36.00
38.00		0			37.00
39.00		0			38.00
40.00		0			39.00
41.00		0			40.00
42.00	Total deductions (sum of lines 37-41)	0			41.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to wkst. G-3, line 4)		31,296,504		42.00
					43.00

1.00	Total patient revenues (from wkst. G-2, Part I, column 3, line 28)	1.00	
2.00	Less contractual allowances and discounts on patients' accounts	58,528,803	1.00
3.00	Net patient revenues (line 1 minus line 2)	27,739,836	2.00
4.00	Less total operating expenses (from wkst. G-2, Part II, line 43)	30,788,967	3.00
5.00	Net income from service to patients (line 3 minus line 4)	31,296,504	4.00
	OTHER INCOME	-507,537	5.00
6.00	Contributions, donations, bequests, etc	16,410	6.00
7.00	Income from investments	7,283	7.00
8.00	Revenues from telephone and telegraph service	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	46,386	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	952	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	4,831	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER (SPECIFY)	0	24.00
25.00	Total other income (sum of lines 6-24)	87,663	25.00
26.00	Total (line 5 plus line 25)	163,525	26.00
27.00	OTHER EXPENSES (SPECIFY)	-344,012	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-344,012	29.00

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C3-14-00
Baltimore, Maryland 21244-1850



October 31, 2011

Refer To: FAHB2

Ms Becky Dolin
Health Financial Systems
8109 Laguna Blvd.
Elk Grove, California 95758

Dear Ms. Dolin:

We have reviewed your hospital (Form CMS 2552-10) cost report software program and submission of the electronic cost report (ECR) and print image files. Based on our review, your cost report software accurately reflects and incorporates the most recent revisions to the cost report instructions, forms, and electronic reporting specifications. The trade name of your system is known by this office as **MCRIF32**. This approval is for submission of ECR and print image files covering Transmittal 1/Transmittal 2 for the cost reporting periods beginning on or after **May 1, 2010**.

Your approved Vendor code, which is to be placed in the first record of all transmitted electronic files (location 38-40), is **A05**. The ECR Spec date of **2010121(05/01/2010)** (location 52-58) is also required in the aforementioned record. We also request that your providers have working knowledge of Table 5 - Cost Center Coding, pages 40-777 - 36-781 in Section 4095 of CMS Pub. 15-2, Chapter 40.

Notification will be sent to all Medicare Administrative Contractors (MAC) as necessary. Attached are the nine (9) associates, which are authorized to market your system. State agencies may accept the computerized worksheets for titles V and XIX in those States that use the CMS cost reporting worksheets for Medicaid.

Our approval does not apply to any alternatives to the bases or sequence of allocation recommended for cost finding in the official CMS forms. Any variations in the bases or sequence of allocation for Medicare reimbursement purposes must be reviewed and approved by the affected provider's MAC prior to the beginning of the first cost reporting period to which such variation is to apply. The procedures that providers must follow to obtain intermediary approval are contained in the Provider Reimbursement Manual, Part 1 (CMS Pub. 15-1), section 2313.

Our approval of these computer prepared cost reports is subject to all of the terms and conditions contained in all of the applicable sections in Provider Reimbursement Manual, Part 2 (CMS Pub. 15-2), Chapter 1.

Sincerely,

Nadia Massuda

Nadia Massuda, CPA
Technical Advisor
Division of Cost Reporting
Chronic Care Policy Group
Centers for Medicare & Medicaid Services

Enclosure

cc:
Eric Swanson
Shelly Foxworthy

Approved Associates of Health Financial Systems

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Marc Levy
280 Fore Street
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Portland, Maine 04101

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Parrish, Moody & Fikes, P.C.
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LarsonAllen LLP
Zane Junker, CPA
109 North Main Street
Austin, MN 55912-0217

ST. CHARLES PSYCH RESEARCH

Inclusive	Inpatient	\$650.00			
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SAINT JOHNS/MERCY (SJM)MBH

Inclusive	Inpatient	8/19/2006	6/1/2008	12/1/2009	
DISTRICT 9	PHP	\$625.00	\$670.00	\$715.00	
MERCY	IOP	\$275.00	\$288.00	\$315.00	
CARPENTERS	CD RES	\$175.00	\$225.00	\$245.00	
IBEW #1	Detox 126	\$450.00	\$475.00	\$495.00	
	ECT			\$485.00	

10/1/10 to Coventry-Mhnet

SELF PAY

Exclusive	Inpatient		\$500.00	\$500.00	
Exclusive	PHP		\$150.00	\$150.00	
Exclusive	IOP		\$125.00	\$125.00	
Inclusive	CD RES		\$500.00	\$500.00	
Exclusive	partial boarding		250.00+SR.00	250.00+SR.00	

TRICARE NORTH

Exclusive	Inpatient		\$425.00	11/1/2009	\$536.00
	PHP				NO CONTRACT
	IOP				NO CONTRACT
	CD RES				NO CONTRACT

TRICARE WEST

Exclusive	Inpatient	4/1/2003	4/1/2003	10/01/2003	10/1/2011
	PHP	\$478.45	\$550.29	\$563.32	\$581.02
RATES SUBJECT TO CHANGE	IOP	NO CONTR	NO CONTRACT	NO CONTRACT	NO CONTRACT
	CD RES	NO CONTR	NO CONTRACT	NO CONTRACT	NO CONTRACT

UBH/OPTUM

Exclusive	Inpatient	2/1/2009	2/6/2010	2/6/2011	
MEDICARE COMPLETE	PHP	\$690.00	\$718.00	\$747.00	
UBH SECURE HORIZONS	PHP Boarding 913	\$300.00	\$312.00	\$324.00	
GOLDEN RULE	IOP	\$190.00	\$198.00	\$206.00	
UBH/OPTUM	IOP Boarding 944	\$500.00	\$520.00	\$541.00	
	CD RES				
	Detox			747.00	
	ECT				