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SC Court of Appeals

THE STATE OF SOUTH CAROLINA
IN THE COURT OF APPEALS

APPEAL FROM THE ADMINISTRATIVE LAW COURT
The Honorable S. Phillip Lenski, Administrative Law Judge

Appellate Case No. 2015-000056
Lower Court Docket No. 11-ALJ-07-0575-CC

Amisub of South Carolina, Inc. d/b/a Piedmont Medical Center
d/b/a Fort Mill Medical Center ..... Respondent,

v.

South Carolina Department of Health and Environmental Control
and The Charlotte-Mecklenburg Hospital Authority, d/b/a Carolinas
Medical Center-Fort Mill ..... Respondents,

Of whom The Charlotte-Mecklenburg Hospital Authority, d/b/a Carolinas
Medical Center-Fort Mill, is ..... Appellant.

RECORD ON APPEAL – VOLUME XVI OF XVII

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Cost Report data

420087
ROPER HOSPITAL
316 CALHOUN ST
CHARLESTON, SC 29401

[Electronic Record Code: 268372 - 1996]
Type of Facility: Short Term Acute Care
Type of Control: Voluntary Nonprofit, Other
Classification: Urban

Bed Size:	316
Total Annual Discharges:	14,341
Total Patient Revenue:	$1,198,766,426

Period: 01/01/2010 - 12/31/2010
Status: As Submitted

Fiscal Intermediary: Palmetto Government Benefits Administrators

Medicare Inpatient Characteristics

DSH Ratio:	0.049300
DSH Amount:	$3,122,461
Outlier Amount:	$2,942,620
IME Amount:	$0
GME Amount:	$0
Total IP Reimbursement:	$75,127,489
Total IP Costs:	$96,879,076
NPR Date:	00/00/0000
NPR Settlement Amount:	$678,382
NPR Settlement Percent:	0.90 %

[Date Generated. 03/20/2013]

Source
This report was downloaded from www.CostReportData.com and is derived from raw electronic data obtained from the federal Centers for Medicare and Medicaid Services (CMS). Online information is updated quarterly as new data become available. Before using this report it may be advisable to check the website for updates and new reporting periods.

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Legend:

Identification
A hospital's Medicare provider number, name, and address are taken from Worksheet S-2. The Electronic Code is a code assigned by CostReportData.com to assist in resolving questions.

Type of Facility
The type of facility is determined from the last four digits of its Medicare provider number.

Type of Control
A hospital's type of control is taken from the HCRIS file.

Bed Size
The number of staffed beds is taken from Worksheet S-3, Part I, line 12, col.1. Cost report instructions define staffed beds as, "the number of beds available for use by patients at the end of the cost reporting period. A bed means an adult bed, pediatric bed, birthing room, or newborn bed maintained in a patient care area for lodging patients in acute, long term, or domiciliary areas of the hospital. Beds in labor room, birthing room, postanesthesia, postoperative recovery rooms, outpatient areas, emergency rooms, ancillary departments, nurses' and other staff residences, and other such areas which are regularly maintained and utilized for only a portion of the stay of patients (primarily for special procedures or not for inpatient lodging) are not termed a bed for these purposes.

Total Annual Discharges
The total number of inpatient discharges (all payors) is taken from Worksheet S-3, part I, line 12, column 15.

Total Patient Revenue
The total patient revenue (inpatient and outpatient) is taken from Worksheet G-2, part I, line 25, column 3.

Period
The beginning and ending dates for a cost report are taken from Worksheet S-2, line 17.

Status
The status of a cost report is taken from the HCRIS file.

Fiscal Intermediary
Medicare Fiscal Intermediaries (FIs) are private insurance companies that serve as the federal government's agents in the administration of the Medicare program, including the payment of claims. The name of the FI is obtained from a hospital's most recent Medicare cost report.

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Petitioner's Trial Exhibit 079A

Disproportionate Share (DSH Amount and DSH Ratio)
Medicare provides additional payment to hospitals that treat a disproportionate share of low-income patients. Qualifying hospitals receive a percentage increase in Medicare payments. This percentage increase varies depending on the ratio of low income patients and on certain statutory calculations. The Disproportionate SHare (DSH) ratio is taken from Worksheet E, Part A, line 4.03. The amount of DSH payments is from Worksheet E, Part A, line 4.04.

Outlier Amount
Medicare makes additional payments to hospitals for patients with costs that are extraordinarily high due to severity of illness and/or complicating conditions. The amount of outlier payments is from Worksheet E, Part A, line 2.01 (or line 2 for discharges occurring prior to October 1, 1997).

IME Amount
Teaching hospitals receive additional Medicare payment due to the indirect costs associated with medical education programs. These payments are intended to cover the costs of additional tests and procedures ordered by interns and residents over and above what would have been ordered by more experienced physicians. The amount of the Indirect Medical Education (IME) adjustment is from Worksheet E, Part A, line 3.24 (or line 3.03 for cost reporting periods ending on or before September 30, 1997).

GME Amount
Medicare pays a hospital for the costs of an approved direct Graduate Medical Education (GME) program. These costs include the direct cost of salaries and benefits for interns, residents, and teachers. The amount of GME payment is from Worksheet E, Part A, line 11.

Total IP Reimbursement
The total amount of Medicare inpatient reimbursement for the cost reporting period is from Worksheet E, Part A, line 16 for PPS hospitals or from Worksheet E-3, Part I, line 17 or Worksheet E-3, Part II, Line 30 for non-PPS hospitals.

Total IP Costs
Total IP Costs corresponding to Total IP Reimbursement are calculated in the cost report and summarized on Worksheet D-1, Part II, line 49.

NPR Date
At the close of its fiscal year, a provider must submit a cost report to the FI showing the costs it incurred during the fiscal year and the proportion of those costs to be allocated to Medicare. The FI reviews the cost report, determines the total amount of Medicare reimbursement due the provider and issues the provider a Notice of Program Reimbursement (NPR). The NPR date is obtained from the most recent cost report data (HCRIS). There is no NPR date for cost reports as submitted or as amended by the provider (see Status above).

NPR Settlement Amount
The NPR Settlement Amount is the Balance due provider/(Program). It is the difference between the Total IP Reimbursement (above) and the total interim payments for the cost reporting period less any tentative settlements previously made by the FI. The Balance due provider/(Program) is from Worksheet E, Part A, line 29 for PPS hospitals or from Worksheet E-3, Part I, line 20 or Worksheet E-3, Part II, Line 33 for non-PPS hospitals.

NPR Settlement Percentage
This NPR settlement percentage is the NPR settlement amount as a percentage of total inpatient reimbursement. (It is calculated from the data elements previously defined.)

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ROPER HOSPITAL - CHARLESTON, SC
Cost report status - As Submitted
[Record code 268372 - 1996]

HOSPITAL AND HOSPITAL HEALTHCARE COMPLEX IDENTIFICATION DATA	PROVIDER NO 420087	PERIOD FROM 01/01/2010 TO 12/31/2010	WORKSHEET S-2 PART I

Hospital and Hospital Health Care Complex Address:

1	Street: 316 CALHOUN ST		P.O.Box:	1
1.01	City: CHARLESTON	State: SC	ZIP: 29401	County: CHARLESTON	1.01

Hospital and Hospital-Based Component Identification:

	Component	Component Name	Provider Number	NPI Number	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
	0	1	2	2.01	3	4	5	6	
2	Hospital	ROPER HOSPITAL	420087		10/01/79		P	O	2
3.00	Subprovider		42T087		10/01/92		P	O	3.00
4	Swing Beds-SNF								4
5	Swing Beds-NF								5
6	Hospital-Based SNF								6
7.00	Hospital-Based NF								7.00
8	Hospital-Based OLTC								8
9.00	Hospital-Based HHA		427042		02/12/88		P	O	9.00
11.00	Separately Certified ASC								11.00
12.00	Hospital-Based Hospice								12.00
14.00	Hospital-Based Health Clinic								14.00
15.00	Outpatient Rehab. Clinic								15.00
16.00	Renal Dialysis								16.00

17	Cost Reporting Period	From: 01/01/2010	To: 12/31/2010		17
			1	2	
18	Type of Control (see instructions)		2		18

Type of Hospital/subprovider (see instructions)

19	Hospital		1	19
20.00	SubComponent 1 - 42T087		5	20.00

Other Information

21	Indicate if your hospital is either (1) urban or (2) rural at the end of the cost reporting period in column 1. If your hospital is geographically classified or located in a rural area, is your bed size in accordance with CFR 42 412.105 less than or equal to 100 beds, enter in column 2 "Y" for yes or "N" for no.					21
21.01	Does your facility qualify and is currently receiving payment for disproportionate share hospital adjustment in accordance with 42 CFR 412.106?Enter in column 1 "Y" for yes or "N" for no. Is this facility subject to the provisions of 42 CFR 412.106(c)(2) (Pickle amendment hospitals)? Enter in column 2 "Y" for yes or "N" for no.			Y	N	21.01
21.02	Has your facility received a new geographic reclassification status changes after the first day of the cost reporting period from rural to urban and vice versa? Enter "Y" for yes and "N" for no. If yes, enter in column 2 the effective date (mm/dd/yyyy) (See instructions)					21.02
21.03	Enter in column 1 your geographic location either (1) urban (2) rural If you answered urban in column 1 indicate if you received either a wage or standard geographic reclassification to a rural location, enter in column 2 "Y" for yes and "N" for no. If column 2 is yes enter in column 3 the effective date (mm/dd/yyyy) (see instruction). Does your facility contain 100 or fewer beds in accordance with 42 CFR 412.105? Enter in column 4 "Y" for yes and "N" for no. Enter in column 5 the providers actual MSA or CBSA	1	N		N	16700	21.03
21.04	For standard Geographic classification (not wage), what is your status at the beginning of the cost reporting period. Enter (1) urban and (2) rural.			1		21.04
21.05	For standard Geographic classification (not wage), what is your status at the end of the cost reporting period. Enter (1) urban and (2) rural.			1		21.05
21.06	Does this hospital qualifies for the three year transition (or applicable extension) of hold harmless payments for small rural hospital under the prospective payment system for hospital outpatient services under DRA §5105 or MIPPA §147, ACA §3121, or MMEA §108? (See instructions). Enter "Y" for yes, and "N" for no.			N		21.06
21.07	Does this hospital qualify as an SCH with 100 or fewer beds under MIPPA§147? Enter "Y" for yes and "N" for no.(See instructions) Is this an SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 or MMEA §108? Enter in colun 2 "Y" for yes or "N" for no.(See instructions)				N		21.07
21.08	Which method is used to determine Medicaid days on S-3, Part I, col. 5 Enter in column 1, "1" if it is based on date of admission, "2" if it based on census days, or "3" if it is based on date of discharge. Is this method different than the method used in the preceeding cost reporting period? Enter in column 2,"Y" for yes or "N" for no.				N		21.08
22	Are you classified as a referral center?			N			22
23	Does this facility operate a transplant center? If yes, enter certification date(s) in column 2 and termination date(s) in column 3 (mm/dd/yyyy) below:			N			23
23.01	If this is a Medicare certified kidney transplant center, enter the certification date in col. 2 and termination in col. 3.						23.01
23.02	If this is a Medicare certified heart transplant center, enter the certification date in col. 2 and termination in col. 3.						23.02
23.03	If this is a Medicare certified liver transplant center, enter the certification date in col. 2 and termination in col. 3.						23.03
23.04	If this is a Medicare certified lung transplant center, enter the certification date in col. 2 and termination in col. 3.						23.04
23.05	If Medicare pancreas transplant are performed see instructions for entering certification and termination date.						23.05

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HOSPITAL AND HOSPITAL HEALTHCARE COMPLEX IDENTIFICATION DATA	PROVIDER NO 420087	PERIOD FROM 01/01/2010 TO 12/31/2010	WORKSHEET S-2 PART I	

23.06	If this is a Medicare certified intestinal transplant center, enter the certification date in col. 2 and termination in col. 3.					23.06
23.07	If this is a Medicare certified islet transplant center, enter the certification date in col. 2 and termination in col. 3.					23.07
24	If this is an organ procurement organization (OPO), enter the OPO number in column 2 termination date in col 3.					24
24.01	If this is a Medicare Transplant Center, enter CCN in col. 2, the certification or recertification date after (12/26/2007) in column 3 (mm/dd/yyyy).					24.01
25	Is this a teaching hospital or affiliated with a teaching hospital and you are receiving payments for I & R?		N			25
25.01	Is this teaching program approved in accordance with CMS Pub. 15-I, chapter 4?					25.01
25.02	If line 25.01 is yes, was Medicare participation and approved teaching program status in effect during the first month of the cost reporting period? If yes, complete Worksheet E-3, Part IV. If no, complete Worksheet D-2, Part II.					25.02
25.03	As a teaching hospital, did you elect cost reimbursement for physicians as defined in CMS Pub. 15-I, section 2148? If yes, complete Worksheet D-9.		N			25.03
25.04	Are you claiming costs on line 70 of Worksheet A? If yes, complete Worksheet D-2, Part I.		N			25.04
25.05	Has your facility direct GME FTE cap (column 1) or IME FTE cap (column 2) been reduced under 42 CFR §413.79(c)(3) or 42 CFR §412.105(f)(1)(iv)(B)? Enter "Y" for yes and "N" for no in the applicable columns. (see instructions)		N	N		25.05
25.06	Has your facility received additional direct GME FTE resident cap slots or IME FTE residents cap slots under 42 CFR 413.79(c)(4)or 42 CFR 412.105(f)(1)(iv)(C)? Enter "Y" for yes and "N" for no in the applicable columns (see instructions).		N	N		25.06
25.07	Has your facility trained residents in non-provider setting during the cost reporting period? Enter "Y" for yes or "N" for no in column 1.					25.07
25.08	If line 25.07 is yes, enter in column 1 the weighted number of non-primary care FTE residents attributable to rotations occurring in all non-provider settings.					25.08
25.09	If line 25.07 is yes, use lines 25.09 through 25.59 as necessary to identify the program name in column 1, the program code in column 2, and the number unweighted primary care residents FTEs by program in column 3 for each primary care specialty program in which residents are trained.(see instructions)					25.09
26	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the C/R period Enter beginning and ending dates of SCH status on line 26.01. Subscript line 26.01 for number of periods in excess of one and enter subsequent dates					26
26.01	Enter the applicable SCH dates: (see instructions)	Beginning:	Ending:			26.01
27	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? If yes, enter the agreement date (mm/dd/yyyy) in column 2.		N			27
28	If this facility contains a hospital-based SNF, are all patients under managed care or there were no Medicare utilization enter "Y", if "N" complete lines 28.01 and 28.02.					28
28.01	If hospital-based SNF, enter appropriate transition period 1, 2, 3, or 100 in column 1. Enter in columns 2 and 3 the wage index adjustment factor before and on or after the October 1st (see instrctions)					28.01
28.02	Enter in column 1 the hospital based SNF facility specific rate (from your fiscal intermediary) if you have not transitioned to 100% SNP PPS payment. In column 2 enter the facility classification Urban(1) or Rural(2). In column 3, enter the SNF MSA code or two character state code if a Rural based facility. In column 4, enter the SNF CBSA code or two character state code if a Rural based facility					28.02
	A notice published in the "Federal Register" Vol. 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. Enter in column 1 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 6, column 3. Indicate in column 2 "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (See instructions)					
28.03	Staffing					28.03
28.04	Recruitment					28.04
28.05	Retention of employees					28.05
28.06	Training					28.06
28.07	Other (Specify)					28.07
29	Is this a rural hospital with a certified SNF which has fewer than 50 beds in the aggregate for both components, using the swing bed optional method of reimbursement?		N			29
30	Does this hospital qualify as a rural primary care hospital (RPCH)/Critical Access Hospital (CAH)? (see 42 CYR 485.606ff)		N			30
30.01	If so, is this the initial 12 month period for the facility operated as an RPCH/CAH? See 42 CFR 413.70.					30.01
30.02	If this facility qualifies as an RPCH/CAH, has it elected the all-inclusive method of payment for outpatient services? (See instructions)					30.02
30.03	If this facility qualifies as a CAH is it eligible for cost reimbursement for ambulance services? If yes, enter in column 2 the date of eligibility determination (date must be on or after 12/21/2000)					30.03
30.04	If this facility qualifies as a CAH is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes and "N" for no. If yes, the GME elimination would not be on Worksheet B, Part I, column 26 and the program would be cost reimbursed. If yes also complete Worksheet D-2, Part II.					30.04
31	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR 412.113(c).		N			31
31.01			N			31.01
31.02			N			31.02
	Miscellaneous Cost Reporting information					
32	Is this an all-inclusive provider? If yes, enter the method used (A, B, or E only) in column 2.		N			32
33	Is this a new hospital under 42 CFR 412.300 PPS capital? Enter "Y for yes and "N" for no in column 1. If yes, for cost reporting periods beginning on or after October 1, 2002, do you elect to be reimbursed at 100% Federal capital payment? Enter "Y for yes and "N" for no in column 2.		N			33

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HOSPITAL AND HOSPITAL HEALTHCARE COMPLEX IDENTIFICATION DATA	PROVIDER NO 420087	PERIOD FROM 01/01/2010 TO 12/31/2010	WORKSHEET S-2 PART I

34	Is this a new hospital under 42 CFR 413.40(f)(1)(i) TEFRA?	N			34
35	Have you established a new subprovider (excluded unit) under 42 CFR 413.40(f)(1)(i)?	N			35
35.01		N			35.01
		V	XVIII	XIX	
	Prospective Payment System (PPS)-Capital	1	2	3	
36	Do you elect fully prospective payment methodology for capital costs? (See instructions)		Y		36
36.01	Does your facility qualify and receive payment for disproportionate share in accordance with 42 CFR 412.320? (See instructions)		Y		36.01
37	Do you elect hold harmless payment methodology for capital costs? (See instructions)		N		37
37.01	If you are a hold harmless provider, are you filing on the basis of 100% of the Federal rate?				37.01
	Title XIX inpatient services				
38	Do you have title XIX inpatient hospital services?	Y			38
38.01	Is this hospital reimbursed for title XIX through the cost report either in full or in part?				38.01
38.02	Does the title XIX program reduce capital following the Medicare methodology?				38.02
38.03	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (See instructions)	N			38.03
38.04	Do you operate an ICF/MF facility for purposes of title XIX?	N			38.04
40	Are there any related organization or home office costs as defined in CMS Pub. 15-1, Chapter 10? If yes, and this facility is part of a chain organization, enter in col. 2 the chain home office chain number. (See inst.) If this facility is part of a chain organization enter the name and address of the home office on lines 40.01-40.03.	Y	42H055		40
40.01	Name: CAREALLIANCE HEALTH SERVICES	FI/Contractor's Name: PALMETTO GBA	FI/Contractor's Number:		40.01
40.02	Street: 315 CALHOUN ST. SUITE 107	PO Box:			40.02
40.03	City: CHARLESTON	State: SC	Zip Code: 29401		40.03
41	Are provider based physicians' costs included in Worksheet A?				41
42	Are physical therapy services provided by outside suppliers?	N			42
42.01	Are occupational therapy services provided by outside suppliers?	N			42.01
42.02	Are speech pathology services provided by outside suppliers?	N			42.02
43	Are respiratory therapy services provided by outside suppliers?	N			43
44	If you are claiming cost for renal services on Worksheet A, are they inpatient services only?	Y			44
45	Have you changed your cost allocation methodology from the previously filed cost report? See CMS Pub. 15-II, section 3617. If yes, enter the approval date (mm/dd/yyyy) in column 2.	N			45
45.01	Was there a change in the statistical basis?				45.01
45.02	Was there a change in the order of allocation?				45.02
45.03	Was there a change to the simplified cost finding method?				45.03
46	If you are participating in the NHCMQ demonstration project (must have a hospital-based SNF) during this cost reporting period, enter the phase (see instructions).				46

If this facility contains a provider that qualifies for an exemption from the application of the lower of costs or charges, enter "Y" for each component and type of service that qualifies for the exemption. Enter "N" if not exempt. (See 42 CFR 413.13.)		Part A 1	Part B 2	Outpatient ASC 3	Outpatient Radiology 4	Outpatient Diagnostic 5	
47	Hospital	N	N	N	N	N	47
48	Subprovider	N	N	N	N	N	48
49	SNF						49
50	HHA	N	N				50
51	Outpatient Rehab. Providers (specify)						51

52	Does this hospital claim expenditures for extraordinary circumstances in accordance with 42 CFR 412.348(e)? (See instructions)	N			52
52.01	If you are a fully prospective or hold harmless provider are you eligible for the special exceptions payment pursuant to 42 CFR 412.348(g)? If yes, complete Worksheet L, Part IV.	N			52.01
53	If you are a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in this C/R period. Enter beginning and ending dates of MDH status on line 53.01. Subscript line 53.01 for number of periods in excess of one and enter subsequent dates.				53
53.01	MDH Period Beginning:	Ending:			53.01
54	List amounts of malpractice premiums and paid losses: Premiums: 51,864	Paid losses:	and/or Self Insurance:		54
54.01	Are malpractice premiums and paid losses reported in other than the Administrative and General cost center? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			54.01
55	Does your facility qualify for additional prospective payment in accordance with 42 CFR 412.107. Enter "Y" for yes and "N" for no.	N			55

56	Are you claiming ambulance costs? If yes, enter in column 2 the payment limit provided from your fiscal intermediary and the applicable dates for those limits in column 0. If this is the first year of operation no entry is required in column 2. If column 1 is Y, enter Y or N in column 3 whether this is your first year of operations for rendering ambulance services. Enter in column 4, if applicable, the fee schedules amounts for the period beginning on or after 4/1/2002.	Date 0	Y or N 1	Limit 2	Y or N 3	Fees 4	56
			N				
56.01	Enter subsequent ambulance payment limit as required. Subscript if more than 2 limits apply. Enter in column 4 the fee schedules amounts for initial or subsequent periods as applicable.						56.01
57	Are you claiming nursing and allied health costs? (See instructions)					Y	57

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HOSPITAL AND HOSPITAL HEALTHCARE COMPLEX IDENTIFICATION DATA	PROVIDER NO 420087	PERIOD FROM 01/01/2010 TO 12/31/2010	WORKSHEET S-2 PART I		

58	Are you an Inpatient Rehabilitation Facility (IRF), or do you contain an IRF subprovider? Enter in column 1 "Y" for yes and "N" for no. If yes have you made the election for 100% Federal PPS reimbursement? Enter in column 2 "Y for yes and "N" for no. This option is only available for cost reporting periods beginning on or after 1/1/2002 and before 10/1/2002.		Y		58
58.01	If line 58 column 1 is Y, does the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter in column 1 "Y" for yes or "N" for no. Is the facility training residents in a new teaching programs in accordance with FR Vol. 70, No. 156 dated August 15, 2005 page 47929? Enter in column 2 "Y" for yes or "N" for no. If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions). If the current cost reporting period covers the beginning of the fourth enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5 . (see instructions)	N			58.01
59	Are you a Long Term Care Hospital (LTCH), or do you contain a LTCH subprovider? Enter in column 1 "Y" for yes and "N" for no. If yes, have you made the election for 100% Federal PPS reimbursement? Enter in column 2 "Y" for yes and "N" for no. (See instructions)		N		59
60	Are you an Inpatient Psychiatric Facility (IPF), or do you contain an IPF subprovider? Enter in column 1 "Y" for yes and "N" for no. If yes, is the IPF or IPF subprovider a new facility? Enter in column 2 "Y for yes and "N" for no. (see instructions)		N		60
60.01	If line 60 column 1 is Y, does 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. Is the facility training residents in a new teaching programs in accordance with 42 CFR Sec. 412 424 (d)(1)(iii)(2)? Enter in column 2 "Y" for yes or "N" for no. If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions). If the current cost reporting period covers the beginning of the fourth enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5 . (see instructions)				60.01

Multicampus

61	Is this facility part of a Multicampus hospital that has one or more campuses in different CBSA? Enter "Y" for yes and "N" for no.					N	61
	If line 61 is yes, enter the name in col. 0, County in col. 1, state in col. 2, Zip in col 3, CBSA in col. 4 and FTE/Campus in col. 5.	County	State	ZIP Code	CBSA	FTE/ Campus	
		1	2	3	4	5	
62	Name:						62

Settlement data

63	Was there a change to the simplified cost finding method?	Y	05/04/11	63

Miscellaneous data

64	Did this facility incur and report costs for implantable devices charged to patient? Enter in column 1 "Y" for yes or "N" for no.	Y	64

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA	PROVIDER NO 420087	PERIOD FROM 01/01/2010 TO 12/31/2010	WORKSHEET S-3 PART I

	Component	No. of Beds	Bed Days Available	I/P Days / O/P Visits / Trips						Total All Patients	OBS Beds		Interns & Residents FTEs			Full Time Equivalent		Discharges				
				Title V	Title XVIII	Not Covered (LTAC only)	Title XIX				Admitted	Not Admitted	Total	Less I&R Replacing Non-Phys. Anest.	Net	Employees on Payroll	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
							Total	OBS Admitted	OBS Not Admitted													
		1	2	3	4	4 01	5	5 01	5,02	6	6 01	6 02	7	8	9	10	11	12	13	14	15	
1	Hospital Adults &Peds. (col 3,4,&5), exclude Swing Beds, OBS Bed, and Hospice Days	278	127,310		34,795		2,886			62,922									7,162	713	14,341	1
2	HMO						4,276															2
3	Hospital Adults &Peds Swing Bed SNF																					3
4	Hospital Adults & Peds. Swing Bed NF																					4
5	Total Adults & Peds. (exclude OBS beds)	278	127,310		34,795		2,886			62,922												5
6	Intensive Care Unit	38	13,870		5,126		361			8,753												6
7	Coronary Care Unit																					7
8	Burn Intensive Care Unit																					8
9	Surgical Intensive Care Unit																					9
10.00	Other Special Care (specify)																					10.00
11	Nursery						326			1,354												11
12	Total (see instructions)	316	141,180		39,921		3,573			73,029						1,949.38			7,162	713	14,341	12
13	RPCH\CAH visits																					13
14.00	SubComponent 1 - 42T087	52	18,980		8,693					14,038						93.61			675		1,022	14.00
15	Skilled Nursing Facility																					15
16	Nursing Facility																					16
17	Other Long Term Care																					17
18	Home Health Agency				36,982		1,163			54,404						78.90						18
20	ASC (Distinct Part)																					20
21	Hospice (Distinct Part)																					21
23	Outpatient Rehab. Provider (specify)																					23
24	RHC/FQHC (specify)																					24
25	Total (sum of lines 12-24)	368														2,121.89						25
26	Observation Bed Days									2,600												26
27	Ambulance Trips				3,741																	27
28	Employee discount days (see instru.)																					28
29	Labor & delivery days (see instructions)																					29

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HOSPITAL WAGE INDEX INFORMATION		PROVIDER NO.: 420087		PERIOD: FROM 01/01/2010 TO 12/31/2010		WORKSHEET S-3. PART II	
PART II - WAGE DATA	Amount Reported	Reclass. of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 1 ± col. 2)	Paid Hours Related to Salaries in col. 3	Average Hourly Wage (col. 3÷ col. 4)	Data Source	
	1	2	3	4	5	6	
SALARIES							
1 Total Salaries (see instructions)	118,586,250	-1,023,643	117,562,607	4,472,022	26.29		1
2 Non-physician anesthetist Part A							2
3 Non-physician anesthetist Part B							3
4 Physician-Part A							4
4.01 Teaching physician salaries (see instructions)							4.01
5 Physician-Part B	1,073,266		1,073,266	6,392	167.90		5
5.01 Non-physician-Part B							5.01
6 Interns & residents (in an approved program)							6
6.01 Contractd Services I&R (see instructions)							6.01
7 Home office personnel							7
8 SNF							8
8.01 Excluded area salaries (see instructions)	12,912,994	-16,773	12,896,221	466,532	27.64		8.01
OTHER WAGES & RELATED COSTS							
9 Contract labor (see instructions)	652,201		652,201	17,103	38.13		9
9.01 Pharmacy services under contract							9.01
9.02 Laboratory services under contract							9.02
9.03 Management and administrative services							9.03
10 Contract labor: physician-Part A	633,704		633,704	5,512	114.96		10
10.01 Teaching physician under contract (see instru.)							10.01
11 Home office salaries & wage-related costs	19,191,719		19,191,719	533,880	35.95		11
12 Home office: physician Part A							12
12.01 Teaching physician salaries (see instructions)							12.01
WAGE-RELATED COSTS							
13 Wage-related costs (core)	21,143,455		21,143,455			CMS 339	13
14 Wage-related costs (other)						CMS 339	14
15 Excluded areas	2,598,295		2,598,295			CMS 339	15
16 Non-physician anesthetist Part A						CMS 339	16
17 Non-physician anesthetist Part B						CMS 339	17
18 Physician Part A						CMS 339	18
18.01 Part A teaching physicians (see instructions)						CMS 339	18.01
19 Physician Part B	216,837		216,837			CMS 339	19
19.01 Wage-related costs (RHC/FQHC)						CMS 339	19.01
20 Interns & residents (in an approved program)						CMS 339	20
OVERHEAD COSTS - DIRECT SALARIES							
21 Employee Benefits	796	-796					21
22 Administrative & General	10,024,416	-648,810	9,375,606	401,051	23.38		22
22.01 Administrative & General under contract (see inst.)	38,207		38,207	2,019	18.92		22.01
23 Maintenance & Repairs							23
24 Operation of Plant	2,285,986		2,285,986	99,635	22.94		24
25 Laundry & Linen Service							25
26 Housekeeping	2,714,310		2,714,310	213,313	12.72		26
26.01 Housekeeping under contract (see instructions)							26.01
27 Dietary	74,167	-74,167					27
27.01 Dietary under contract (see inst.)	2,159,518		2,159,518	170,753	12.65		27.01
28 Cafeteria							28
29 Maintenance of Personnel							29
30 Nursing Administration	2,326,236		2,326,236	69,554	33.45		30
31 Central Services and Supply							31
32 Pharmacy							32
33 Medical Records & Medical Records Library	1,710,708		1,710,708	96,003	17.82		33
34 Social Service							34
35 Other General Service							35

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HOSPITAL WAGE INDEX INFORMATION		PROVIDER NO.: 420087		PERIOD FROM 01/01/2010 TO 12/31/2010		WORKSHEET S-3, PART III	
	Amount Reported	Reclass. of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 1 ± col. 2)	Paid Hours Related to Salaries in col. 3	Average Hourly Wage (col. 3 ÷ col. 4)	Data Source	
	1	2	3	4	5	6	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1 Net Salaries (see instructions)	119,710,709	-1,023,643	118,687,066	4,638,402	25.59		1
2 Excluded area salaries (see instructions)	12,912,994	-16,773	12,896,221	466,532	27.64		2
3 Subtotal salaries (line 1 minus line 2)	106,797,715	-1,006,870	105,790,845	4,171,870	25.36		3
4 Subtotal other wages & related costs (see inst.)	20,477,624		20,477,624	556,496	36.80		4
5 Subtotal wage-related costs (see inst.)	21,143,455		21,143,455		19.99		5
6 Total (sum of lines 3 thru 5)	148,418,794	-1,006,870	147,411,924	4,728,366	31.18		6
7 Net salaries (see instructions)							7
8 Excluded area salaries							8
9 Subtotal salaries (line 7 minus line 8)							9
10 Subtotal other wages & related costs (see inst.)							10
11 Subtotal wage-related costs (see inst.)							11
12 Total (sum of lines 9 thru 11)							12
13 Total overhead costs (see inst.)	21,334,344	-723,773	20,610,571	1,052,328	19.59		13

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HOSPITAL UNCOMPENSATED CARE DATA	PROVIDER NO: 420087	PERIOD: FROM: 01/01/2010 TO: 12/31/2010	WORKSHEET S-10

Uncompensated Care Information			
1	Do you have a written charity policy?		1
2	Are patients write-offs identified as charity? If yes answer lines 2.01 thru 2.04		2
2.01	Is it at the time of admission?		2.01
2.02	Is it at the time of first billing?		2.02
2.03	Is it after some collection effort has been made?		2.03
2.04	Other methods of write-offs (specify)		2.04
3	Are charity write-offs made for partial bills?		3
4	Are charity determinations based upon administrative judgment without financial data?		4
5	Are charity determinations based upon income data only?		5
6	Are charity determinations based upon net worth (assets) data?		6
7	Are charity determinations based upon income and net worth data?		7
8	Does your accounting system separately identify bad debt and charity care? If yes answer 8.01		8
8.01	Do you separately account for inpatient and outpatient services?		8.01
9	Is discerning charity from bad debt a high priority in your institution? If no answer 9.01 thru 9.04		9
9.01	Is it because there is not enough staff to determine eligibility?		9.01
9.02	Is it because there is no financial incentive to separate charity from bad debt?		9.02
9.03	Is it because there is no clear directive policy on charity determination?		9.03
9.04	Is it because your institution does not deem the distinction important?		9.04
10	If charity determinations are made based upon income data, what is the maximum income that can be earned by patients (single without dependent) and still determined to be a charity write off??		10
11	If charity determinations are made based upon income data, is the income directly tied to Federal poverty level? If yes answer lines 11.01 thru 11.04		11
11.01	Is the percentage level used less than 100% of the Federal poverty level?		11.01
11.02	Is the percentage level used between 100% and 150% of the Federal poverty level?		11.02
11.03	Is the percentage level used between 150% and 200% of the Federal poverty level?		11.03
11.04	Is the percentage level greater than or equal to 200% of the Federal poverty level?		11.04
12	Are partial write-offs given to higher income patients on a gradual scale?		12
13	Is there charity consideration given to high net worth patients who have catastrophic or other extraordinary medical expenses?		13
14	Is your hospital State or local government owned? If yes answer line 14.01 and 14.02		14
14.01	Do you receive direct financial support from the government entity for the purpose of providing uncompensated care?		14.01
14.02	What percentage of the amount on line 14.01 is from government funding?		14.02
15	Do you receive restricted grants for rendering care to charity patients?		15
16	Are other non-restricted grants used to subsidize charity care?		16
Uncompensated Care Revenues			
17	Revenues from uncompensated care	5,500,438	17
17.01	Gross Medicaid Revenues	10,705,712	17.01
18	Revenues from State and local indigent care programs	11,223,157	18
19	Revenues related to SCHIP (see instructions)		19
20	Restricted grants	12,479	20
21	Non-restricted grants		21
22	Total Gross Uncompensated Care Revenues	27,441,786	22
Uncompensated Care Costs			
23	Total charges for patients covered by State and local indigent care programs	4,539,140	23
24	Cost to Charge Ratio (Wkst C, Part I, column 3 line 103, divided by column 8, line 103)	0.272385	24
25	Total State and local indigent care program cost (line 23 x line 24)	1,236,394	25
26	Total SCHIP charges from your records		26
27	Total SCHIP cost, (line 24 x line 26)		27
28	Total gross Medicaid charges from your records	37,091,810	28
29	Total gross Medicaid cost (line 24 x line 28)	10,103,253	29
30	Other uncompensated care charges from your records (see instructions)	91,274,906	30
31	Uncompensated care cost (line 24 x line 30)	24,861,915	31
32	Total uncompensated cost to the hospital (Sum of lines 25, 27, and 29)	11,339,647	32

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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES			PROVIDER NO: 420087		PERIOD: FROM 01/01/2010 TO 12/31/2010			WORKSHEET A	
		COST CENTER DESCRIPTIONS (omit cents)	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	RECLASSIFIED TRIAL BALANCE (col. 3 + col. 4)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 5 + col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	0100	Old Capital Related Costs-Buildings and Fixtures								1
2	0200	Old Capital Related Costs-Movable Equipment								2
3	0300	New Capital Related Costs-Buildings and Fixtures		20,588,185	20,588,185	-8,012,045	12,576,140	15,202,798	27,778,938	3
4	0400	New Capital Related Costs-Movable Equipment		363,835	363,835	8,012,045	8,375,880	4,581,362	12,957,242	4
5	0500	Employee Benefits	796	25,491,844	25,492,640	397,234	25,889,874	1,074,240	26,964,114	5
6.15	0600	Other Administrative & General	10,024,416	54,931,069	64,955,485	16,773	64,972,258	-9,510,562	55,461,696	6.15
7	0700	Maintenance and Repairs								7
8	0800	Operation of Plant	2,285,986	11,933,944	14,219,930		14,219,930	-109,324	14,110,606	8
9	0900	Laundry and Linen Service		1,247,126	1,247,126		1,247,126		1,247,126	9
10	01000	Housekeeping	2,714,310	558,412	3,272,722		3,272,722		3,272,722	10
11	1100	Dietary	74,167	6,339,576	6,413,743		6,413,743		6,413,743	11
12	1200	Cafeteria						-1,902,051	-1,902,051	12
13	1300	Maintenance of Personnel								13
14	1400	Nursing Administration	2,326,236	226,102	2,552,338		2,552,338		2,552,338	14
15	1500	Central Services and Supply								15
16	1600	Pharmacy								16
17	1700	Medical Records & Medical Records Library	1,710,708	232,934	1,943,642		1,943,642	-17,009	1,926,633	17
18	1800	Social Service								18
19.00	1900	Other General Service (specify)								19.00
20	2000	Nonphysician Anesthetics								20
21	2100	Nursing School								21
22	2200	Intern & Res. Service-Salary & Fringes (Approved)								22
23	2300	Intern & Res. Other Program Costs (Approved)								23
24	2400	Paramedical Ed. Program (specify)	135,353	4,567	139,920	-16,773	123,147	-1,950	121,197	24
		INPATIENT ROUTINE SERVICE COST CENTERS								
25	2500	Adults and Pediatrics (General Routine Care)	28,222,439	2,645,164	30,867,603	-969,755	29,897,848	-25,363	29,872,485	25
26	2600	Intensive Care Unit	6,253,006	1,111,344	7,364,350		7,364,350		7,364,350	26
27	2700	Coronary Care Unit								27
28	2800	Burn Intensive Care Unit								28
29	2900	Surgical Intensive Care Unit								29
30.00	3000	Other Special Care (specify)								30.00
31.00	3100	SubComponent 1 - 42T087	4,919,100	559,771	5,478,871		5,478,871	-4,397	5,474,474	31.00
33	3300	Nursery	836,186	149,457	985,643		985,643	-32,170	953,473	33
34	3400	Skilled Nursing Facility								34

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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES			PROVIDER NO: 420087			PERIOD: FROM 01/01/2010 TO 12/31/2010		WORKSHEET A	
COST CENTER DESCRIPTIONS (omit cents)			SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	RECLASSIFIED TRIAL BALANCE (col. 3 + col. 4)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 5 + col. 6)	
			1	2	3	4	5	6	7	
35.00	3500	Nursing Facility								35.00
36	3600	Other Long Term Care								36
		ANCILLARY SERVICE COST CENTERS								
37.05	3700	Operating Room	9,320,073	17,172,285	26,492,358		26,492,358	-3,070,161	23,422,197	37.05
38	3800	Recovery Room	2,412,962	219,480	2,632,442		2,632,442		2,632,442	38
39.05	3900	Delivery Room & Labor Room				969,755	969,755		969,755	39.05
40.00	4000	Anesthesiology								40.00
41.05	4100	Radiology-Diagnostic	7,658,158	5,509,630	13,167,788		13,167,788	-614,504	12,553,284	41.05
42.05	4200	Radiology-Therapeutic	3,396,875	1,985,146	5,382,021		5,382,021	-40,103	5,341,918	42.05
43	4300	Radioisotope								43
44.05	4400	Laboratory	5,662,100	5,381,441	11,043,541		11,043,541	-1,273,609	9,769,932	44.05
44.45	4400	Vascular Lab	874,994	352,665	1,227,659		1,227,659	5,194	1,232,853	44.45
45	4500	PBP Clinical Laboratory Services-Program Only								45
46.00	4600	Whole Blood & Packed Red Blood Cells								46.00
47	4700	Blood Storing, Processing, & Trans	328,195	3,304,387	3,632,582		3,632,582	-1,097	3,631,485	47
48	4800	Intravenous Therapy								48
49.05	4900	Respiratory Therapy	2,366,385	475,679	2,842,064		2,842,064	-14,780	2,827,284	49.05
50.05	5000	Physical Therapy	3,343,891	226,218	3,570,109		3,570,109		3,570,109	50.05
51	5100	Occupational Therapy								51
52	5200	Speech Pathology								52
53.05	5300	Electrocardiology	630,079	33,250	663,329		663,329		663,329	53.05
53.40	5300	Cardiac Catheterization Laboratory	2,367,053	1,290,392	3,657,445		3,657,445	-80,899	3,576,546	53.40
54	5400	Electroencephalography								54
55	5500	Medical Supplies Charged to Patients								55
55.30	5530	Implantable Devices Charged to Patients		24,756,096	24,756,096		24,756,096		24,756,096	55.30
56	5600	Drugs Charged to Patients	5,138,129	19,761,236	24,899,365		24,899,365	-19,410	24,879,955	56
57	5700	Renal Dialysis								57
58	5800	ASC (Non-Distinct Part)								58
59.30	5900	Other Ancillary Cost Centers	629,509	529,916	1,159,425		1,159,425	-153,771	1,005,654	59.30
		OUTPATIENT SERVICE COST CENTERS								
60.00	6000	Clinic								60.00
61	6100	Emergency	7,096,603	10,398,485	17,495,088		17,495,088	-9,746,889	7,748,199	61
62.00	6200	Observation Beds								62.00
63.00		Other Outpatient Service (specify)								63.00
		OTHER REIMBURSABLE COST CENTERS								
64	6400	Home Program Dialysis								64
65	6500	Ambulance Services	1,258,832	252,781	1,511,613		1,511,613		1,511,613	65

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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES			PROVIDER NO: 420087				PERIOD: FROM 01/01/2010 TO 12/31/2010		WORKSHEET A	
COST CENTER DESCRIPTIONS (omit cents)			SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	RECLASSIFIED TRIAL BALANCE (col. 3 + col. 4)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 5 + col. 6)	
			1	2	3	4	5	6	7	
66.00	6600	Durable Medical Equipment-Rented								66.00
67.00	6700	Durable Medical Equipment-Sold								67.00
68	6800	Other Reimbursable (specify)								68
69.00	6900	Outpatient Rehabilitation Provider (specify)								69.00
70	7000	Intern-Resident Service (not appvd. tchng. prgm.)								70
71	7100	Home Health Agency	5,510,088	1,039,690	6,549,778	-397,234	6,152,544		6,152,544	71
		SPECIAL PURPOSE COST CENTERS								
82	8200	Lung Acquisition								82
83	8300	Kidney Acquisition								83
84	8400	Livery Acquisition								84
85.00	8500	Heart Acquisition								85.00
86	8600	Other Organ Acquisition (specify)								86
88	8800	Interest Expense								88
89	8900	Utilization Review-SNF								89
90	9000	Other Capital-Related Costs (see instructions)								90
92	9200	Ambulatory Surgical Center (Distinct Part)								92
93	9300	Hospice								93
94	9400	Other Special Purpose (specify)								94
95		SUBTOTALS (sum of lines 1-94)	117,496,629	219,072,107	336,568,736		336,568,736	-5,754,455	330,814,281	95
		NONREIMBURSABLE COST CENTERS								
96	9600	Gift, Flower, Coffee Shop, & Canteen	35,611	72,253	107,864		107,864	-81,121	26,743	96
97	9700	Research								97
98	9800	Physicians' Private Offices								98
99	9900	Nonpaid Workers								99
100		Other Nonreimbursable (specify)	1,054,010	1,994,811	3,048,821		3,048,821	-1,811,527	1,237,294	100
101		TOTAL (sum of lines 95-100)	118,586,250	221,139,171	339,725,421		339,725,421	-7,647,103	332,078,318	101

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ANALYSIS OF CHANGES DURING COST REPORTING PERIOD IN CAPITAL ASSET BALANCES OF HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX CERTIFIED TO PARTICIPATE IN HEALTH CARE PROGRAMS	PROVIDER NO: 420087	PERIOD: FROM 01/01/2010 TO 12/31/2010	WORKSHEET A7 Parts 1 & 2

PART I - ANALYSIS OF CHANGES IN OLD CAPITAL ASSET BALANCES

	Description	Beginning Balances	Acquisitions			Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
			Purchases	Donation	Total				
		1	2	3	4	5	6	7	
1	Land								1
2	Land Improvements								2
3	Buildings and Fixtures								3
4	Building Improvements								4
5	Fixed Equipment								5
6	Movable Equipment								6
7	Subtotal (sum of lines 1-6)								7
8	Reconciling Items								8
9	Total (line 7 minus line 8)								9

PART II - ANALYSIS OF CHANGES IN NEW CAPITAL ASSET BALANCES

	Description	Beginning Balances	Acquisitions			Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
			Purchases	Donation	Total				
		1	2	3	4	5	6	7	
1	Land	3,872,178					3,872,178		1
2	Land Improvements	2,547,769	52,262		52,262		2,600,031		2
3	Buildings and Fixtures	126,244,442					126,244,442		3
4	Building Improvements	92,832,515	6,014,035		6,014,035		98,846,550		4
5	Fixed Equipment	1,708,298	71,954		71,954		1,780,252		5
6	Movable Equipment	94,970,865	11,342,840		11,342,840	9,704,344	96,609,361		6
7	Subtotal (sum of lines 1-6)	322,176,067	17,481,091		17,481,091	9,704,344	329,952,814		7
8	Reconciling Items		-278,990		-278,990		-278,990		8
9	Total (line 7 minus line 8)	322,176,067	17,760,081		17,760,081	9,704,344	330,231,804		9

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RECONCILIATION OF CAPITAL COSTS CENTERS	PROVIDER NO: 420087	PERIOD: FROM 01/01/2010 TO 12/31/2010	WORKSHEET A7, PARTS III & IV

PART III - RECONCILIATION OF CAPITAL COSTS CENTERS

Description		COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instru.)	Insurance	Taxes	Other Capital-Related Costs	Total (sum of cols. 5-7)	
		1	2	3	4	5	6	7	8	
1	Old Capital Related Costs-Buildings and Fixtures									1
2	Old Capital Related Costs-Movable Equipment									2
3	New Capital Related Costs-Buildings and Fixtures									3
4	New Capital Related Costs-Movable Equipment									4
5	Total (sum of lines 1-4)									5

Description *		SUMMARY OF OLD AND NEW CAPITAL							
		Depreciation	Lease	Interest	Insurance (see instru.)	Taxes (see instru.)	Other Capital-Related Costs (see instru.)	Total (1) (sum of cols. 9-14)	
		9	10	11	12	13	14	15	
1	Old Capital Related Costs-Buildings and Fixtures								1
2	Old Capital Related Costs-Movable Equipment								2
3	New Capital Related Costs-Buildings and Fixtures	26,003,535	1,791,361	-15,958				27,778,938	3
4	New Capital Related Costs-Movable Equipment	12,593,407	363,835					12,957,242	4
5	Total (sum of lines 1-4)	38,596,942	2,155,196	-15,958				40,736,180	5

(1) The amounts on lines 1 thru 4 must equal the corresponding amounts on Worksheet A, column 7, lines 1 thru 4. Columns 9 through 14 should include related Worksheet A-6 reclassificatons, Worksheet A-8 adjustments, and Worksheet A-8-1 related organizations and home office costs (See instructions.)

PART IV - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 THRU 4

Description *		SUMMARY OF OLD AND NEW CAPITAL							
		Depreciation	Lease	Interest	Insurance (see instru.)	Taxes (see instru.)	Other Capital-Related Costs (see instru.)	Total (1) (sum of cols. 9-14)	
		9	10	11	12	13	14	15	
1	Old Capital Related Costs-Buildings and Fixtures								1
2	Old Capital Related Costs-Movable Equipment								2
3	New Capital Related Costs-Buildings and Fixtures	18,546,104	2,042,081					20,588,185	3
4	New Capital Related Costs-Movable Equipment		363,835					363,835	4
5	Total (sum of lines 1-4)	18,546,104	2,405,916					20,952,020	5

(1) The amount in columns 9 thru 14 must equal the amount on Worksheet A, column 2, lines 1 thru 4. Enter in each column the approporiate amounts including any directly assigned cost which may have been included in Worksheet A, column 2, lines 1 thru 4. All lines numbers except line 5 are to be consistent with Worksheet A line numbers for capital cost centers.

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	ADJUSTMENTS TO EXPENSES	PROVIDER NO: 420087	PERIOD: FROM: 01/01/2010 TO: 12/31/2010	WORKSHEET A-8			
	DESCRIPTION (1)	(2)		Epense Classification on Worksheet A to/from which the amount is to be adjusted		Wkst. A-7 Ref.	
		BASIS/CODE	AMOUNT	COST CENTER		LINE #	
		1	2	3	4	5	
1	Investment income - old buildings and fixtures (chapter 2)			Old Buildings and Fixtures	1		1
2	Investment income - old movable equipment (chapter 2)			Old Moveable Equipment	2		2
3	Investment income - new buildings and fixtures (chapter 2)			New Buildings and Fixtures	3		3
4	Investment income - new movable equipment (chapter 2)			New Movable Equipment	4		4
5	Investment income - other (chapter 2)						5
6	Trade, quantity, and time discounts (chapter 8)						6
7	Refunds and rebates of expenses (chapter 8)						7
8	Rental of provider space by suppliers (chapter 8)						8
9	Telephone services (pay stations excluded) (chapter 21)						9
10	Television and radio service (chapter 21)						10
11	Parking lot (chapter 21)						11
12	Provider-based physician adjustment	Wkst A-8-2					12
13	Sale of scrap, waste, etc. (chapter 23)						13
14	Related organization transactions (chapter 10)	Wkst A-8-1	13,796,908				14
15	Laundry and linen service						15
16	Cafeteria-employees and guests						16
17	Rental of quarters to employee and others						17
18	Sale of medical and surgical supplies to other than patients						18
19	Sale of drugs to other than patients						19
20	Sale of medical records and abstracts						20
21	Nursing school (tuition, fees, books, etc.)						21
22	Vending machines						22
23	Income from imposition of interest, finance or penalty charges (chapter 21)						23
24	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments						24
25	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	Wkst A-8-3 Wkst A-8-4		Respiratory Therapy	49		25
26	Adjustment for physical therapy costs in excess of limitation (chapter 14)	Wkst A-8-3 Wkst A-8-4		Physical Therapy	50		26
27	Adjustment for HHA physical therapy costs in excess of limitation	Wkst A-8-3		HHA	74		27
28	Utilization review - physicians' compensation (chapter 21)			Utilization Review - SNF	89		28
29	Depreciation - old buildings and fixtures			Old Buildings and Fixtures	1		29
30	Depreciation - old movable equipment			Old Moveable Equipment	2		30
31	Depreciation - new buildings and fixtures			New Buildings and Fixtures	3		31
32	Depreciation - new movable equipment			New Movable Equipment	4		32
33	Non-physician Anesthetist			Non-physician Anesthetist	20		33
34	Physicians' assistant						34
35	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	Wkst A-8-4		Occupational Therapy	51		35
36	Adjustment for speech pathology costs in excess of limitation (chapter 14)	Wkst A-8-4		Speech Pathology	52		36
37	Other adjustments (specify) (3)		-21,444,011				37
50	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 101.)		-7,647,103				50

(1) Description - all chapter references in this column pertain to HCFA Pub. 15-I. (2) Basis for adjustment (see instructions). A. Costs - if cost, including applicable overhead, can be determined. B. Amount Received - if cost cannot be determined. (3) Additional adjustments may be made on lines 37 thru 49 and subscripts thereof. Note:See instructions for column 5 referencing to Worksheet A-7.

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Statement of Costs of Services from Related Organizations and Home Office Costs				PROVIDER NO: 420087	PERIOD: FROM: 01/01/2010 TO: 12/31/2010		WORKSHEET A-8-1 Part A	
A. Costs incurred and adjustments required as a result of transactions with related organizations or the claiming of home office costs:								
	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount included in Wkst. A, column 5	Net Adjustments (col.4 - col.5) *	Wkst. A-7 Ref.	
	1	2	3	4	5	6	7	
1	5		CONTRA EMPLOYEE BENEFITS	20,068,829	18,777,752	1,291,077		1
2	6		CORPORATE ALLOCATION	19,152,666	42,517,233	-23,364,567		2
3	6		HO SALARIES	15,966,349		15,966,349		3
4.00	3		CRC - BLDG & FIX NEW	15,411,261		15,411,261	9	4.00
4.01	4		CRC - MME NEW	97,963		97,963	9	4.01
4.02	4		SHARED CRC MME	4,489,606		4,489,606	9	4.02
4.03	44		PURCHASED SVC OTHER	-341,607	-341,607			4.03
4.04	59		PURCHASED SVC OTHER	71,458	225,229	-153,771		4.04
4.05	3		RLTD PARTY RENT EXPENSE		61,158	-61,158	10	4.05
4.06	3		RLTD PARTY RENT EXPENSE		4,438	-4,438	10	4.06
4.07	53		VASCULAR SERVICES EXPENSE	124,586		124,586		4.07
4.08	6		CONTRA SUPPORT FROM FOUND	-55,955	-55,955			4.08
4.09	8		CONTRA SUPPORT FROM FOUND	-3,732	-3,732			4.09
4.10	14		CONTRA SUPPORT FROM FOUND	-241,850	-241,850			4.10
4.11	31		CONTRA SUPPORT FROM FOUND	-28,276	-28,276			4.11
4.12	33		CONTRA SUPPORT FROM FOUND	-6,087	-6,087			4.12
4.13	41		CONTRA SUPPORT FROM FOUND	-11,221	-11,221			4.13
4.14	42		CONTRA SUPPORT FROM FOUND	-73,590	-73,590			4.14
4.15	44		CONTRA SUPPORT FROM FOUND	-455	-455			4.15
4.16	53		CONTRA SUPPORT FROM FOUND	-38,182	-38,182			4.16
4.17	61		CONTRA SUPPORT FROM FOUND	-80,525	-80,525			4.17
4.18	100		CONTRA SUPPORT FROM FOUND	-1,427,687	-1,427,687			4.18
5	TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet A-8, column 2, line 14.			73,073,551	59,276,643	13,796,908		5
	*The amounts on lines 1-4 and subscripts as appropriate are transfered in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost.For related organizational or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.							

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Statement of Costs of Services from Related Organizations and Home Office Costs	PROVIDER NO: 420087	PERIOD: FROM: 01/01/2010 TO: 12/31/2010	WORKSHEET A-8-1 Part B

B. Interrelationship to related organization(s) and/or home office:

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet. This information is used by the Health Care Financing Administration and its intermediaries in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act.If you do not provide all or any part of the requested information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

				Related Organization(s) and/or Home Office			
	Symbol (1)	Name	Percentage of Ownership		Percentage of Ownership	Type of Business	
	1	2	3	4	5	6	
1	B			CAREALLIANCE HEALTH SERVI		HOME OFFICE	1
G	NON-FINANCIAL			ST FRANCIS XAVIER HOSPITA		SHARED SERVICES	2
G	NON-FINANCIAL			ROPER FOUNDATION		FUND RAISING	3
4							4

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

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.

B. Corporation, partnership, or other organization has financial interest in provider.

C. Provider has financial interest in corporation, partnership, or other organization.

D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.

E. Individual is director, officer, administrator, or key person of provider and related organization.

F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

G. Other (financial or non-financial) specify _____

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COST ALLOCATION - GENERAL SERVICE COSTS							PROVIDER NO.: 420087		PERIOD: FROM 01/01/2010 TO 12/31/2010		WORKSHEET B. PART I	
	COST CENTER DESCRIPTIONS	NET EXPENSES FOR COST ALLOCATION (from Wkst. A, col. 7)	OLD CAPITAL RELATED COSTS		NEW CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	SUBTOTAL (cols 0-5)	ADMINIS-TRATIVE & GENERAL	MAIN-TENANCE & REPAIRS	OPERATION OF PLANT	
			BLDGS & FIXTURES	MOVABLE EQUIPMENT	BLDGS. & FIXTURES	MOVABLE EQUIPMENT						
		0	1	2	3	4	5	5a	6	7	8	
	GENERAL SERVICE COST CENTERS											
1	Old Capital Related Costs-Buildings and Fixtures											1
2	Old Capital Related Costs-Movable Equipment											2
3	New Capital Related Costs-Buildings and Fixtures	27,778,938			27,778,938							3
4	New Capital Related Costs-Movable Equipment	12,957,242				12,957,242						4
5	Employee Benefits	26,964,114			131,362		27,095,476					5
6.15	Other Administrative & General	55,461,696			2,344,137	988,255	2,160,861	60,954,949	61,407,571			6.15
7	Maintenance and Repairs											7
8	Operation of Plant	14,110,606			5,975,965	576,030	526,867	21,189,468	4,632,802		25,822,270	8
9	Laundry and Linen Service	1,247,126			75,002	493		1,322,621	289,174		100,206	9
10	Housekeeping	3,272,722			420,011	25,802	625,586	4,344,121	949,786		561,152	10
11	Dietary	6,413,743			612,312	70,010		7,096,065	1,551,462		818,073	11
12	Cafeteria	-1,902,051						-1,902,051				12
13	Maintenance of Personnel											13
14	Nursing Administration	2,552,338			136,013	138,257	536,144	3,362,752	735,222		181,719	14
15	Central Services and Supply											15
16	Pharmacy											16
17	Medical Records and Medical Records Library	1,926,633			255,476	2,429	394,279	2,578,817	563,825		341,325	17
18	Social Service											18
19.00	Other General Service (specify)											19.00
20	Nonphysician Anesthetists											20
21	Nursing School											21
22	Intern &Res. Service-Salary &Fringes (Approved)											22
23	Intern &Res. Other Program Costs (Approved)											23
24	Paramedical Ed. Program (specify)	121,197			33,715	84	27,330	182,326	39,863		45,044	24
	INPATIENT ROUTINE SERVICE COST CENTERS											
25	Adults and Pediatrics (General Routine Care)	29,872,485			6,541,437	780,373	6,307,021	43,501,316	9,511,075		8,739,619	25
26	Intensive Care Unit	7,364,350			1,166,606	300,916	1,441,174	10,273,046	2,246,068		1,558,631	26

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COST ALLOCATION - GENERAL SERVICE COSTS							PROVIDER NO.: 420087		PERIOD: FROM 01/01/2010 TO 12/31/2010		WORKSHEET B. PART I	
COST CENTER DESCRIPTIONS		NET EXPENSES FOR COST ALLOCATION (from Wksht. A, col. 7)	OLD CAPITAL RELATED COSTS		NEW CAPITAL RELATED COSTS							
			BLDGS. & FIXTURES	MOVABLE EQUIPMENT	BLDGS. & FIXTURES	MOVABLE EQUIPMENT	EMPLOYEE BENEFITS	SUBTOTAL (cols. 0-5)	ADMINIS-TRATIVE & GENERAL	MAIN-TENANCE & REPAIRS	OPERATION OF PLANT	
		0	1	2	3	4	5	5a	6	7	8	
27	Coronary Care Unit											27
28	Burn Intensive Care Unit											28
29	Surgical Intensive Care Unit											29
30.00	Other Special Care (specify)											30.00
31.00	SubComponent 1 - 42T087	5,474,474			1,083,274	122,569	1,133,739	7,814,056	1,708,442		1,447,297	31.00
33	Nursery	953,473			78,464	9,562	185,291	1,226,790	268,222		104,831	33
34	Skilled Nursery Facility											34
35.00	Nursing Facility											35.00
36	Other Long Term Care											36
	ANCILLARY SERVICE COST CENTERS											
37.05	Operating Room	23,422,197			2,885,377	2,502,807	2,148,062	30,958,443	6,876,529		3,854,978	37.05
38	Recovery Room	2,632,442			189,524	56,090	556,132	3,434,188	750,841		253,212	38
39.05	Delivery Room & Labor Room	969,755			346,920	39,729	197,602	1,554,006	339,763		463,499	39.05
40.00	Anesthesiology											40.00
41.05	Radiology-Diagnostic	12,553,284			1,128,744	2,920,986	1,765,029	18,368,043	4,224,380		1,508,047	41.05
42.05	Radiology-Therapeutic	5,341,918			595,905	1,858,210	782,902	8,578,935	1,884,798		796,153	42.05
43	Radioisotope											43
44.05	Laboratory	9,769,932			830,178	208,496	1,304,984	12,113,590	2,792,992		1,109,151	44.05
44.45	Vascular Lab	1,232,853			626,375	125,060	202,950	2,187,238	478,211		836,862	44.45
45	PBP Clinical Laboratory Services-Program Only											45
46.00	Whole Blood & Packed Red Blood Cells											46.00
47	Blood Storing, Processing, & Trans.	3,631,485			38,835	78,043	75,641	3,824,004	836,069		51,885	47
48	Intravenous Therapy											48
49.05	Respiratory Therapy	2,827,284			232,110	83,132	545,397	3,687,923	819,547		310,108	49.05
50.05	Physical Therapy	3,570,109			406,020	30,867	770,690	4,777,686	1,086,219		542,459	50.05
51	Occupational Therapy											51
52	Speech Pathology											52
53.05	Electrocardiology	663,329			117,948	248,991	145,219	1,175,487	257,005		157,583	53.05
53.40	Cardiac Catheterization Laboratory	3,576,546			367,438	870,978	545,551	5,360,513	1,172,006		490,911	53.40
54	Electroencephalography											54

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COST ALLOCATION - GENERAL SERVICE COSTS							PROVIDER NO.: 420087		PERIOD: FROM 01/01/2010 TO 12/31/2010		WORKSHEET B, PART I	
COST CENTER DESCRIPTIONS		NET EXPENSES FOR COST ALLOCATION (from Wkst. A, col. 7)	OLD CAPITAL RELATED COSTS		NEW CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	SUBTOTAL (cols. 0-5)	ADMINIS-TRATIVE & GENERAL	MAIN-TENANCE & REPAIRS	OPERATION OF PLANT	
			BLDGS. & FIXTURES	MOVABLE EQUIPMENT	BLDGS. & FIXTURES	MOVABLE EQUIPMENT						
		0	1	2	3	4	5	5a	6	7	8	
55	Medical Supplies Charged to Patients											55
55.30	Implantable Devices Charged to Patients	24,756,096						24,756,096	5,412,599			55.30
56	Drugs Charged to Patients	24,879,955			226,953	95,655	1,184,221	26,386,784	5,889,649		303,218	56
57	Renal Dialysis											57
58	ASAC (Non-Distinct Part)											58
59.30	Other Ancillary Cost Centers	1,005,654			40,710	98,986	145,087	1,290,437	282,137		54,390	59.30
	OUTPATIENT SERVICE COST CENTERS											
60.00	Clinic											60.00
61	Emergency	7,748,199			843,628	196,952	1,576,503	10,365,282	2,882,300		1,127,121	61
62.00	Observation Beds											62.00
63.00	Other Outpatient Service (specify)											63.00
	OTHER REIMBURSABLE COST CENTERS											
64	Home Program Dialysis											64
65	Ambulance Services	1,511,613				122,170	290,132	1,923,915	420,639			65
66.00	Durable Medical Equipment-Rented											66.00
67.00	Durable Medical Equipment-Sold											67.00
68	Other Reimbursable (specify)											68
69.00	Outpatient Rehabilitation Provider (specify)											69.00
70	Intern-Resident Service (not apprvd. tchng. prgm.)											70
71	Home Health Agency	6,152,544				301,354	1,269,949	7,723,847	1,688,719			71
	SPECIAL PURPOSE COST CENTERS											
82	Lung Acquisition											82
83	Kidney Acquisition											83
84	Liver Acquisition											84
85.00	Heart Acquisition											85.00
86	Other Organ Acquisition (specify)											86
92	Ambulatory Surgical Center (Distinct Part)											92
93	Hospice											93
94	Other Special Purpose (specify)											94
95	SUBTOTALS (sum of lines 1-94)	330,814,281			27,730,439	12,853,286	26,844,343	330,410,693	60,816,655		25,757,474	95

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COST ALLOCATION - GENERAL SERVICE COSTS							PROVIDER NO.: 420087		PERIOD: FROM 01/01/2010 TO 12/31/2010		WORKSHEET B. PART I	
COST CENTER DESCRIPTIONS		NET EXPENSES FOR COST ALLOCATION (from Wkst. A, col. 7)	OLD CAPITAL RELATED COSTS		NEW CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	SUBTOTAL (cols. 0-5)	ADMINIS-TRATIVE & GENERAL	MAIN-TENANCE & REPAIRS	OPERATION OF PLANT	
			BLDGS. & FIXTURES	MOVABLE EQUIPMENT	BLDGS. & FIXTURES	MOVABLE EQUIPMENT						
		0	1	2	3	4	5	5a	6	7	8	
	NONREIMBURSABLE COST CENTERS											
96	Gift, Flower, Coffee Shop, & Canteen	26,743				578	8,208	35,529	7,768			96
97	Research											97
98	Physicians' Private Offices											98
99	Nonpaid Workers											99
100	Other Nonreimbursable (specify)	1,237,294			48,499	103,378	242,925	1,632,096	356,837		64,796	100
101	Cross Foot Adjustments											101
102	Negative Cost Centers									-		102
103	Total (sum of lines 95-102)	332,078,318			27,778,938	12,957,242	27,095,476	332,078,318	61,181,260		25,822,270	103

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ROPER HOSPITAL - CHARLESTON, SC
Cost report status - As Submitted
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COST ALLOCATION - GENERAL SERVICE COSTS					PROVIDER NO.: 420087		PERIOD: FROM 01/01/2010 TO 12/31/2010		WORKSHEET B. PART I			
COST CENTER DESCRIPTIONS		LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	MAIN-TENANCE OF PERSONNEL	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & MEDICAL LIBRARY	SOCIAL SERVICE	
		9	10	11	12	13	14	15	16	17	18	
	GENERAL SERVICE COST CENTERS											
1	Old Capital Related Costs-Buildings and Fixtures											1
2	Old Capital Related Costs-Movable Equipment											2
3	New Capital Related Costs-Buildings and Fixtures											3
4	New Capital Related Costs-Movable Equipment											4
5	Employee Benefits											5
6.15	Other Administrative & General											6 15
7	Maintenance and Repairs											7
8	Operation of Plant											8
9	Laundry and Linen Service	1,712,001										9
10	Housekeeping		5,855,059									10
11	Dietary	190,369	9,655,969									11
12	Cafeteria			3,644,689	1,742,638							12
13	Maintenance of Personnel											13
14	Nursing Administration		42,287		39,028		4,361,008					14
15	Central Services and Supply											15
16	Pharmacy											16
17	Medical Records and Medical Records Library		79,428		53,874					3,617,269		17
18	Social Service											18
19.00	Other General Service (specify)											19.00
20	Nonphysician Anesthetists											20
21	Nursing School											21
22	Intern &Res. Service-Salary &Fringes (Approved)											22
23	Intern &Res. Other Program Costs (Approved)											23
24	Paramedical Ed. Program (specify)		10,482		5,742							24
	INPATIENT ROUTINE SERVICE COST CENTERS											
25	Adults and Pediatrics (General Routine Care)	811,546	2,033,749	2,195,934	582,302		2,095,496			1,007,476		25
26	Intensive Care Unit	120,781	362,701	207,452	116,022		415,088			304,609		26

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COST ALLOCATION - GENERAL SERVICE COSTS					PROVIDER NO.: 420087		PERIOD: FROM 01/01/2010 TO 12/31/2010		WORKSHEET B. PART I			
COST CENTER DESCRIPTIONS		LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	MAIN-TENANCE OF PERSONNEL	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & MEDICAL LIBRARY	SOCIAL SERVICE	
		9	10	11	12	13	14	15	16	17	18	
27	Coronary Care Unit											27
28	Burn Intensive Care Unit											28
29	Surgical Intensive Care Unit											29
30.00	Other Special Care (specify)											30.00
31.00	SubComponent 1 - 42T087	106,999	336,793	384,118	109,253		390,879			198,071		31.00
33	Nursery	3,432	24,395		13,387		47,893			16,436		33
34	Skilled Nursery Facility											34
35.00	Nursing Facility											35.00
36	Other Long Term Care											36
	ANCILLARY SERVICE COST CENTERS											
37.05	Operating Room	204,397	897,071		176,093		712,031			966,949		37.05
38	Recovery Room	93,273	58,924		31,337		155,012					38
39.05	Delivery Room & Labor Room	30,523	107,858		14,017		50,160					39.05
40.00	Anesthesiology											40.00
41.05	Radiology-Diagnostic	64,778	350,929		102,028							41.05
42.05	Radiology-Therapeutic	45,067	185,268		51,061							42.05
43	Radioisotope											43
44.05	Laboratory	108	258,105		98,037							44.05
44.45	Vascular Lab	6,068	194,742		17,623							44.45
45	PBP Clinical Laboratory Services-Program Only											45
46.00	Whole Blood & Packed Red Blood Cells											46.00
47	Blood Storing, Processing, & Trans.		12,074		7,504							47
48	Intravenous Therapy											48
49.05	Respiratory Therapy	22,041	72,163		45,330							49.05
50.05	Physical Therapy	14,984	126,233		68,999							50.05
51	Occupational Therapy											51
52	Speech Pathology											52
53.05	Electrocardiology	45,377	36,670		14,379							53.05
53.40	Cardiac Catheterization Laboratory	24,152	114,237		33,718					374,882		53.40
54	Electroencephalography											54

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COST ALLOCATION - GENERAL SERVICE COSTS					PROVIDER NO.: 420087		PERIOD: FROM 01/01/2010 TO 12/31/2010		WORKSHEET B. PART I			
COST CENTER DESCRIPTIONS		LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	MAIN-TENANCE OF PERSONNEL	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & MEDICAL LIBRARY	SOCIAL SERVICE	
		9	10	11	12	13	14	15	16	17	18	
55	Medical Supplies Charged to Patients											55
55.30	Implantable Devices Charged to Patients											55.30
56	Drugs Charged to Patients		70,560		68,953							56
57	Renal Dialysis											57
58	ASAC (Non-Distinct Part)											58
59.30	Other Ancillary Cost Centers	5,608	12,657		11,893		42,529					59.30
	OUTPATIENT SERVICE COST CENTERS											
60 00	Clinic											60 00
61	Emergency	112,867	262,286		75,698		451,920			748,846		61
62.00	Observation Beds											62.00
63.00	Other Outpatient Service (specify)											63.00
	OTHER REIMBURSABLE COST CENTERS											
64	Home Program Dialysis											64
65	Ambulance Services											65
66.00	Durable Medical Equipment-Rented											66.00
67.00	Durable Medical Equipment-Sold											67.00
68	Other Reimbursable (specify)											68
69.00	Outpatient Rehabilitation Provider (specify)											69.00
70	Intern-Resident Service (not apprvd. tchng. prgm.)											70
71	Home Health Agency											71
	SPECIAL PURPOSE COST CENTERS											
82	Lung Acquisition											82
83	Kidney Acquisition											83
84	Liver Acquisition											84
85.00	Heart Acquisition											85 00
86	Other Organ Acquisition (specify)											86
92	Ambulatory Surgical Center (Distinct Part)											92
93	Hospice											93
94	Other Special Purpose (specify)											94
95	SUBTOTALS (sum of lines 1-94)	1,712,001	5,839,981	6,432,193	1,736,278		4,361,008			3,617,269		95

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COST ALLOCATION - GENERAL SERVICE COSTS					PROVIDER NO.: 420087		PERIOD: FROM 01/01/2010 TO 12/31/2010		WORKSHEET B. PART I			
COST CENTER DESCRIPTIONS		LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	MAIN-TENANCE OF PERSONNEL	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & MEDICAL LIBRARY	SOCIAL SERVICE	
		9	10	11	12	13	14	15	16	17	18	
	NONREIMBURSABLE COST CENTERS											
96	Gift, Flower, Coffee Shop, & Canteen				1,050							96
97	Research											97
98	Physicians' Private Offices											98
99	Nonpaid Workers											99
100	Other Nonreimbursable (specify)		15,078	3,223,776	5,310							100
101	Cross Foot Adjustments											101
102	Negative Cost Centers											102
103	Total (sum of lines 95-102)	1,712,001	5,855,059	9,655,969	1,742,638		4,361,008			3,617,269		103

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COST ALLOCATION - GENERAL SERVICE COSTS						PROVIDER NO.: 420087		PERIOD. FROM 01/01/2010 TO 12/31/2010		WORKSHEET B. PART I	
COST CENTER DESCRIPTIONS		OTHER GENERAL SERVICE	NON-PHYSICIAN ANES-THETISTS	NURSING SCHOOL	INTERNS & RESIDENTS SALARY & FRINGES	INTERNS & RESIDENTS PROGRAM COSTS	PARA-MEDICAL EDUCATION (SPECIFY)	SUBTOTAL	INTERN & RESIDENT COST &POST STEPDOWN ADJUSTMENTS	TOTAL	
		19	20	21	22	23	24	25	26	27	
	GENERAL SERVICE COST CENTERS										
1	Old Capital Related Costs-Buildings and Fixtures										1
2	Old Capital Related Costs-Movable Equipment										2
3	New Capital Related Costs-Buildings and Fixtures										3
4	New Capital Related Costs-Movable Equipment										4
5	Employee Benefits										5
6 15	Other Administrative & General										6.15
7	Maintenance and Repairs										7
8	Operation of Plant										8
9	Laundry and Linen Service										9
10	Housekeeping										10
11	Dietary										11
12	Cafeteria										12
13	Maintenance of Personnel										13
14	Nursing Administration										14
15	Central Services and Supply										15
16	Pharmacy										16
17	Medical Records and Medical Records Library										17
18	Social Service										18
19.00	Other General Service (specify)										19.00
20	Nonphysician Anesthetists										20
21	Nursing School										21
22	Intern &Res. Service-Salary &Fringes (Approved)										22
23	Intern &Res. Other Program Costs (Approved)										23
24	Paramedical Ed. Program (specify)									283,457	24
	INPATIENT ROUTINE SERVICE COST CENTERS										
25	Adults and Pediatrics (General Routine Care)						161,777	70,640,290		70,640,290	25
26	Intensive Care Unit						39,736	15,644,134		15,644,134	26

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COST ALLOCATION - GENERAL SERVICE COSTS						PROVIDER NO.: 420087		PERIOD: FROM 01/01/2010 TO 12/31/2010		WORKSHEET B. PART I	
COST CENTER DESCRIPTIONS		OTHER GENERAL SERVICE	NON-PHYSICIAN ANES-THETISTS	NURSING SCHOOL	INTERNS & RESIDENTS SALARY & FRINGES	INTERNS & RESIDENTS PROGRAM COSTS	PARA-MEDICAL EDUCATION (SPECIFY)	SUBTOTAL	INTERN & RESIDENT COST &POST STEPDOWN ADJUSTMENTS	TOTAL	
		19	20	21	22	23	24	25	26	27	
27	Coronary Care Unit										27
28	Burn Intensive Care Unit										28
29	Surgical Intensive Care Unit										29
30.00	Other Special Care (specify)										30.00
31.00	SubComponent 1 - 42T087						21,345	12,517,253		12,517,253	31.00
33	Nursery							1,705,386		1,705,386	33
34	Skilled Nursery Facility										34
35.00	Nursing Facility										35.00
36	Other Long Term Care										36
	ANCILLARY SERVICE COST CENTERS										
37.05	Operating Room						33,766	44,680,257		44,680,257	37.05
38	Recovery Room						6,633	4,783,420		4,783,420	38
39.05	Delivery Room & Labor Room						2,291	2,562,117		2,562,117	39.05
40.00	Anesthesiology										40.00
41.05	Radiology-Diagnostic							24,618,205		24,618,205	41.05
42.05	Radiology-Therapeutic						8,864	11,550,146		11,550,146	42.05
43	Radioisotope										43
44.05	Laboratory							16,371,983		16,371,983	44.05
44.45	Vascular Lab							3,720,744		3,720,744	44.45
45	PBP Clinical Laboratory Services-Program Only										45
46.00	Whole Blood & Packed Red Blood Cells										46.00
47	Blood Storing, Processing, & Trans.							4,731,536		4,731,536	47
48	Intravenous Therapy										48
49.05	Respiratory Therapy							4,957,112		4,957,112	49.05
50.05	Physical Therapy							6,616,580		6,616,580	50.05
51	Occupational Therapy										51
52	Speech Pathology										52
53.05	Electrocardiology							1,686,501		1,686,501	53.05
53.40	Cardiac Catheterization Laboratory							7,570,419		7,570,419	53.40
54	Electroencephalography										54

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COST ALLOCATION - GENERAL SERVICE COSTS						PROVIDER NO.: 420087		PERIOD: FROM 01/01/2010 TO 12/31/2010		WORKSHEET B. PART I	
COST CENTER DESCRIPTIONS		OTHER GENERAL SERVICE	NON-PHYSICIAN ANES-THETISTS	NURSING SCHOOL	INTERNS & RESIDENTS SALARY & FRINGES	INTERNS & RESIDENTS PROGRAM COSTS	PARA-MEDICAL EDUCATION (SPECIFY)	SUBTOTAL	INTERN & RESIDENT COST &POST STEPDOWN ADJUSTMENTS	TOTAL	
		19	20	21	22	23	24	25	26	27	
55	Medical Supplies Charged to Patients										55
55.30	Implantable Devices Charged to Patients							30,168,695		30,168,695	55.30
56	Drugs Charged to Patients							32,719,164		32,719,164	56
57	Renal Dialysis										57
58	ASAC (Non-Distinct Part)										58
59.30	Other Ancillary Cost Centers							1,699,651		1,699,651	59.30
	OUTPATIENT SERVICE COST CENTERS										
60.00	Clinic										60.00
61	Emergency						9,045	16,035,365		16,035,365	61
62.00	Observation Beds										62.00
63.00	Other Outpatient Service (specify)										63.00
	OTHER REIMBURSABLE COST CENTERS										
64	Home Program Dialysis										64
65	Ambulance Services							2,344,554		2,344,554	65
66.00	Durable Medical Equipment-Rented										66.00
67.00	Durable Medical Equipment-Sold										67.00
68	Other Reimbursable (specify)										68
69.00	Outpatient Rehabilitation Provider (specify)										69.00
70	Intern-Resident Service (not apprvd. tchng. prgm.)										70
71	Home Health Agency							9,412,566		9,412,566	71
	SPECIAL PURPOSE COST CENTERS										
82	Lung Acquisition										82
83	Kidney Acquisition										83
84	Liver Acquisition										84
85.00	Heart Acquisition										85.00
86	Other Organ Acquisition (specify)										86
92	Ambulatory Surgical Center (Distinct Part)										92
93	Hospice										93
94	Other Special Purpose (specify)										94
95	SUBTOTALS (sum of lines 1-94)						283,457	326,736,078		326,736,078	95

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COST ALLOCATION - GENERAL SERVICE COSTS						PROVIDER NO : 420087		PERIOD: FROM 01/01/2010 TO 12/31/2010		WORKSHEET B. PART I	
COST CENTER DESCRIPTIONS		OTHER GENERAL SERVICE	NON-PHYSICIAN ANES-THETISTS	NURSING SCHOOL	INTERNS & RESIDENTS SALARY & FRINGES	INTERNS & RESIDENTS PROGRAM COSTS	PARA-MEDICAL EDUCATION (SPECIFY)	SUBTOTAL	INTERN & RESIDENT COST &POST STEPDOWN ADJUSTMENTS	TOTAL	
		19	20	21	22	23	24	25	26	27	
	NONREIMBURSABLE COST CENTERS										
96	Gift, Flower, Coffee Shop, &Canteen							44,347		44,347	96
97	Research										97
98	Physicians' Private Offices										98
99	Nonpaid Workers										99
100	Other Nonreimbursable (specify)							5,297,893		5,297,893	100
101	Cross Foot Adjustments										101
102	Negative Cost Centers										102
103	Total (sum of lines 95-102)						283,457	332,078,318		332,078,318	103

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ROPER HOSPITAL - CHARLESTON, SC
Cost report status - As Submitted
[Record code 268372 - 1996]

COST ALLOCATION - STATISTICAL BASIS						PROVIDER NO. 420087		PERIOD. FROM 01/01/2010 TO 12/31/2010		WORKSHEET B-1	
COST CENTER DESCRIPTIONS		Old Capital Related Cost		New Capital Related Cost							
		Bldgs. & Fixtures (SQ FT)	Movable Equipment (Dollar Value)	Bldgs & Fixtures (SQ FT)	Movable Equipment (Dollar Value)	Employee benefits (gross salaries)	Reconcil-iation	Administrative & General (accum cost)	Maintenance & Repairs (Sq. Ft)	Operation of Plant (Sq Ft)	
		1	2	3	4	5	6A	6	7	8	
	GENERAL SERVICE COST CENTERS										
1	Old Capital Related Costs-Buildings and Fixtures										1
2	Old Capital Related Costs-Movable Equipment										2
3	New Capital Related Costs-Buildings and Fixtures			770,382							3
4	New Capital Related Costs-Movable Equipment				9,303,800						4
5	Employee Benefits			3,643		117,562,600					5
6.15	Other Administrative & General			65,009	709,605	9,375,602		281,433,597			6.15
7	Maintenance and Repairs										7
8	Operation of Plant			165,729	413,612	2,285,985		21,189,468		536,001	8
9	Laundry and Linen Service			2,080	354			1,322,621		2,080	9
10	Housekeeping			11,648	18,527	2,714,309		4,344,123		11,648	10
11	Dietary			16,981	50,270			7,096,063		16,980	11
12	Cafeteria										12
13	Maintenance of Personnel										13
14	Nursing Administration			3,772	99,274	2,326,236		3,362,752		3,771	14
15	Central Services and Supply										15
16	Pharmacy										16
17	Medical Records & Medical Records Library			7,085	1,744	1,710,708		2,578,817		7,084	17
18	Social Service										18
19.00	Other General Service (specify)										19.00
20	Nonphysician Anesthetists										20
21	Nursing School										21
22	Intern & Res. Service-Salary & Fringes (Approved)										22
23	Intern & Res. Other Program Costs (Approved)										23
24	Paramedical Education Program (specify)			935	60	118,580		182,325		934	24
	INPATIENT ROUTINE SERVICE COST CENTERS										
25	Adults and Pediatrics (General Routine Care)			181,411	560,338	27,365,078		43,501,672		181,411	25
26	Intensive Care Unit			32,353	216,069	6,253,005		10,273,046		32,352	26

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COST ALLOCATION - STATISTICAL BASIS						PROVIDER NO 420087		PERIOD FROM 01/01/2010 TO 12/31/2010		WORKSHEET B-1	
COST CENTER DESCRIPTIONS		Old Capital Related Cost		New Capital Related Cost							
		Bldgs. & Fixtures (SQ FT)	Movable Equipment (Dollar Value)	Bldgs & Fixtures (SQ FT)	Movable Equipment (Dollar Value)	Employee benefits (gross salaries)	Reconcil-iation	Administrative & General (accum cost)	Maintenance & Repairs (Sq. Ft)	Operation of Plant (Sq Ft)	
		1	2	3	4	5	6A	6	7	8	
27	Coronary Care Unit										27
28	Burn Intensive Care Unit										28
29	Surgical Intensive Care Unit										29
30.00	Other Special Care (specify)										30.00
31 00	SubComponent 1 - 42T087			30,042	88,009	4,919,098		7,814,057		30,041	31.00
33	Nursery			2,176	6,866	803,945		1,226,791		2,176	33
34	Skilled Nursing Facility										34
35.00	Nursing Facility										35.00
36	Other Long Term Care										36
	ANCILLARY SERVICE COST CENTERS										
37.05	Operating Room			80,019	1,797,112	9,320,071		31,500,396		80,018	37.05
38	Recovery Room			5,256	40,275	2,412,961		3,434,190		5,256	38
39 05	Delivery Room & Labor Room			9,621	28,527	857,361		1,554,005		9,620	39.05
40 00	Anesthesiology										40.00
41.05	Radiology-Diagnostic			31,303	2,097,381	7,658,156		19,415,327		31,303	41.05
42.05	Radiology-Therapeutic			16,526	1,334,266	3,396,876		8,624,783		16,525	42.05
43	Radioisotope										43
44.05	Laboratory			23,023	149,708	5,662,100		12,839,658		23,022	44.05
44 45	Vascular Lab			17,371	89,798	880,565		2,187,237		17,371	44.45
45	PBP Clinical Laboratory Services-Program Only										45
46 00	Whole Blood & Packed Red Blood Cells										46.00
47	Blood Storing, Processing, & Trans.			1,077	56,038	328,193		3,824,005		1,076	47
48	Intravenous Therapy										48
49.05	Respiratory Therapy			6,437	59,692	2,366,383		3,754,396		6,437	49.05
50 05	Physical Therapy			11,260	22,164	3,343,891		4,986,895		11,259	50 05
51	Occupational Therapy										51
52	Speech Pathology										52
53.05	Electrocardiology			3,271	178,785	630,080		1,175,487		3,271	53.05
53 40	Cardiac Catheterization Laboratory			10,190	625,396	2,367,051		5,360,510		10,189	53.40
54	Electroencephalography										54

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COST ALLOCATION - STATISTICAL BASIS						PROVIDER NO 420087		PERIOD: FROM 01/01/2010 TO 12/31/2010		WORKSHEET B-1	
COST CENTER DESCRIPTIONS		Old Capital Related Cost		New Capital Related Cost							
		Bldgs. & Fixtures (SQ FT)	Movable Equipment (Dollar Value)	Bldgs. & Fixtures (SQ FT)	Movable Equipment (Dollar Value)	Employee benefits (gross salaries)	Reconcil-iation	Administrative & General (accum cost)	Maintenance & Repairs (Sq. Ft)	Operation of Plant (Sq Ft)	
		1	2	3	4	5	6A	6	7	8	
55	Medical Supplies Charged to Patients										55
55.30	Implantable Devices Charged to Patients							24,756,098			55.30
56	Drugs Charged to Patients			6,294	68,684	5,138,131		26,992,313		6,293	56
57	Renal Dialysis										57
58	ASC (Non-Distinct Part)										58
59.30	Other Ancillary Cost Centers			1,129	71,076	629,507		1,290,435		1,128	59.30
	OUTPATIENT SERVICE COST CENTERS										
60.00	Clinic										60.00
61	Emergency			23,396	141,419	6,840,175		13,460,545		23,396	61
62.00	Observation Beds										
63.00	Other Outpatient Service (specify)										63.00
	OTHER REIMBURSABLE COST CENTERS										
64	Home Program Dialysis										64
65	Ambulance Services				87,723	1,258,832		1,923,915			65
66.00	Durable Medical Equipment-Rented										66.00
67.00	Durable Medical Equipment-Sold										67.00
68	Other Reimbursable (specify)										68
69.00	Outpatient Rehabilitation Provider (specify)										69.00
70	Intern-Resident Service (not appvd. tchng. prgm)										70
71	Home Health Agency				216,384	5,510,090		7,723,848			71
	SPECIAL PURPOSE COST CENTERS										
82	Lung Acquisition										82
83	Kidney Acquisition										83
84	Liver Acquisition										84
85.00	Heart Acquisition										85.00
86	Other Organ Acquisition (specify)										86
92	Ambulatory Surgical Center (Distinct Part)										92
93	Hospice										93
94	Other Special Purpose (specify)										94
95	SUBTOTALS (sum of lines 1-94)			769,037	9,229,156	116,472,984		278,730,882		534,656	95

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COST ALLOCATION - STATISTICAL BASIS						PROVIDER NO 420087		PERIOD FROM 01/01/2010 TO 12/31/2010		WORKSHEET B-1	
COST CENTER DESCRIPTIONS		Old Capital Related Cost		New Capital Related Cost							
		Bldgs. & Fixtures (SQ FT)	Movable Equipment (Dollar Value)	Bldgs. & Fixtures (SQ FT)	Movable Equipment (Dollar Value)	Employee benefits (gross salaries)	Reconcil-iation	Administrative & General (accum cost)	Maintenance & Repairs (Sq. Ft)	Operation of Plant (Sq Ft)	
		1	2	3	4	5	6A	6	7	8	
	NONREIMBURSABLE COST CENTERS										
96	Gift, Flower, Coffee Shop, & Canteen				415	35,613		35,529			96
97	Research										97
98	Physicians' Private Offices										98
99	Nonpaid Workers										99
100	Other Nonreimbursable (specify)			1,345	74,229	1,054,008		1,632,095		1,344	100
101	Cross foot adjustments										101
102	Negative cost centers										102
103	Cost to be allocated (per Wkst. B, Part I)			27,778,938	12,957,242	27,095,476		61,181,260		25,822,270	103
104	Unit cost multiplier (Wkst. B, Part I)			36.058655	1.392683	0.230477		0.218637*		48.175789	104
105	Cost to be allocated (per Wkst. B, Part II)										105
106	Unit cost multiplier (Wkst. B, Part II)										106
107	Cost to be allocated (per Wkst. B, Part III)										107
108	Unit cost multiplier (Wkst. B, Part III)										108

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COST ALLOCATION - STATISTICAL BASIS						PROVIDER NO.420087		PERIOD: FROM 01/01/2010 TO 12/31/2010		WORKSHEET B-1		
	COST CENTER DESCRIPTIONS	Laundry & Linen Service (LB of Laundry)	Housekeeping (HRs of Service)	Dietary (Meals Served)	Cafeteria (Meals Served)	Maintenance of Personnel (Number Housed)	Nursing Admin ((Direct Nursing Hrs)	Central Services & Supply (Costed Req)	Pharmacy (Costed Req)	Medical Records & Libry (Time Spent)	Social Service (Time Spent)	
		9	10	11	12	13	14	15	16	17	18	
	GENERAL SERVICE COST CENTERS											
1	Old Capital Related Costs-Buildings and Fixtures											1
2	Old Capital Related Costs-Movable Equipment											2
3	New Capital Related Costs-Buildings and Fixtures											3
4	New Capital Related Costs-Movable Equipment											4
5	Employee Benefits											5
6 15	Other Administratve & General											6.15
7	Maintenance and Repairs											7
8	Operation of Plant											8
9	Laundry and Linen Service	1,847,438										9
10	Housekeeping		522,273									10
11	Dietary		16,980	1,026,610								11
12	Cafeteria			387,498	149,313							12
13	Maintenance of Personnel											13
14	Nursing Administration		3,772		3,344		2,172,342					14
15	Central Services and Supply											15
16	Pharmacy											16
17	Medical Records & Medical Records Library		7,085		4,616					352,457,280		17
18	Social Service											18
19.00	Other General Service (specify)											19.00
20	Nonphysician Anesthetists											20
21	Nursing School											21
22	Intern & Res. Service-Salary & Fringes (Approved)											22
23	Intern & Res. Other Program Costs (Approved)											23
24	Paramedical Education Program (specify)		934		491							24
	INPATIENT ROUTINE SERVICE COST CENTERS											
25	Adults and Pediatrics (General Routine Care)	875,747	181,411	233,469	49,892		1,043,826			98,165,840		25
26	Intensive Care Unit	130,336	32,353	22,056	9,941		206,767			29,680,308		26

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COST ALLOCATION - STATISTICAL BASIS						PROVIDER NO.420087		PERIOD: FROM 01/01/2010 TO 12/31/2010		WORKSHEET B-1		
COST CENTER DESCRIPTIONS		Laundry & Linen Service (LB of Laundry)	Housekeeping (HRs of Service)	Dietary (Meals Served)	Cafeteria (Meals Served)	Maintenance of Personnel (Number Housed)	Nursing Admin ((Direct Nursing Hrs)	Central Services & Supply (Costed Req)	Pharmacy (Costed Req)	Medical Records & Libry (Time Spent)	Social Service (Time Spent)	
		9	10	11	12	13	14	15	16	17	18	
27	Coronary Care Unit											27
28	Burn Intensive Care Unit											28
29	Surgical Intensive Care Unit											29
30.00	Other Special Care (specify)											30.00
31.00	SubComponent 1 - 42T087	115,463	30,042	40,838	9,361		194,707			19,299,524		31.00
33	Nursery	3,703	2,176		1,147		23,856			1,601,481		33
34	Skilled Nursing Facility											34
35.00	Nursing Facility											35.00
36	Other Long Term Care											36
	ANCILLARY SERVICE COST CENTERS											
37.05	Operating Room	220,566	80,019		15,088		354,682			94,216,992		37.05
38	Recovery Room	100,651	5,256		2,685		77,215					38
39.05	Delivery Room & Labor Room	32,937	9,620		1,201		24,986					39.05
40.00	Anesthesiology											40.00
41.05	Radiology-Diagnostic	69,902	31,302		8,741							41.05
42.05	Radiology-Therapeutic	48,632	16,525		4,375							42.05
43	Radioisotope											43
44.05	Laboratory	116	23,023		8,400							44.05
44.45	Vascular Lab	6,548	17,371		1,509							44.45
45	PBP Clinical Laboratory Services-Program Only											45
46.00	Whole Blood & Packed Red Blood Cells											46.00
47	Blood Storing, Processing, & Trans.		1,077		642							47
48	Intravenous Therapy											48
49.05	Respiratory Therapy	23,784	6,436		3,883							49.05
50.05	Physical Therapy	16,169	11,260		5,911							50.05
51	Occupational Therapy											51
52	Speech Pathology											52
53.05	Electrocardiology	48,966	3,270		1,232							53.05
53.40	Cardiac Catheterization Laboratory	26,062	10,189		2,889					36,527,528		53.40
54	Electroencephalography											54

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COST ALLOCATION - STATISTICAL BASIS						PROVIDER NO.420087		PERIOD: FROM 01/01/2010 TO 12/31/2010		WORKSHEET B-1		
COST CENTER DESCRIPTIONS		Laundry & Linen Service (LB of Laundry)	Housekeeping (HRs of Service)	Dietary (Meals Served)	Cafeteria (Meals Served)	Maintenance of Personnel (Number Housed)	Nursing Admin ((Direct Nursing Hrs)	Central Services & Supply (Costed Req)	Pharmacy (Costed Req)	Medical Records & Libry (Time Spent)	Social Service (Time Spent)	
		9	10	11	12	13	14	15	16	17	18	
55	Medical Supplies Charged to Patients											55
55.30	Implantable Devices Charged to Patients											55.30
56	Drugs Charged to Patients		6,293		5,908							56
57	Renal Dialysis											57
58	ASC (Non-Distinct Part)											58
59.30	Other Ancillary Cost Centers	6,051	1,129		1,019		21,184					59.30
	OUTPATIENT SERVICE COST CENTERS											
60.00	Clinic											60.00
61	Emergency	121,795	23,395		6,485		225,114			72,965,608		61
62.00	Observation Beds											
63.00	Other Outpatient Service (specify)											63.00
	OTHER REIMBURSABLE COST CENTERS											
64	Home Program Dialysis											64
65	Ambulance Services											65
66.00	Durable Medical Equipment-Rented											66.00
67.												67.
68	Other Reimbursable (specify)											68
69.00	Outpatient Rehabilitation Provider (specify)											69.00
70	Intern-Resident Service (not apprvd. tchng. prgm.)											70
71	Home Health Agency											71
	SPECIAL PURPOSE COST CENTERS											
82	Lung Acquisition											82
83	Kidney Acquisition											83
84	Liver Acquisition											84
85.00	Heart Acquisition											85.00
86	Other Organ Acquisition (specify)											86
92	Ambulatory Surgical Center (Distinct Part)											92
93	Hospice											93
94	Other Special Purpose (specify)											94
95	SUBTOTALS (sum of lines 1-94)	1,847,438	520,928	683,863	148,768		2,172,342			352,457,280		95

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COST ALLOCATION - STATISTICAL BASIS						PROVIDER NO.420087		PERIOD: FROM 01/01/2010 TO 12/31/2010		WORKSHEET B-1		
COST CENTER DESCRIPTIONS		Laundry & Linen Service (LB of Laundry)	Housekeeping (HRs of Service)	Dietary (Meals Served)	Cafeteria (Meals Served)	Maintenance of Personnel (Number Housed)	Nursing Admin ((Direct Nursing Hrs)	Central Services & Supply (Costed Req)	Pharmacy (Costed Req)	Medical Records & Libry (Time Spent)	Social Service (Time Spent)	
		9	10	11	12	13	14	15	16	17	18	
	NONREIMBURSABLE COST CENTERS											
96	Gift, Flower, Coffee Shop, & Canteen				89							96
97	Research											97
98	Physicians' Private Offices											98
99	Nonpaid Workers											99
100	Other Nonreimbursable (specify)		1,344	342,747	454							100
101	Cross foot adjustments											101
102	Negative cost centers											102
103	Cost to be allocated (per Wkst. B, Part I)	1,712,001	5,855,059	9,655,969	1,742,638		4,361,008			3,617,269		103
104	Unit cost multiplier (Wkst. B, Part I)	0.926689	11.210725	9.405675	11.671040		2.007514			0.010263		104
105	Cost to be allocated (per Wkst. B, Part II)											105
106	Unit cost multiplier (Wkst. B, Part II)											106
107	Cost to be allocated (per Wkst. B, Part III)											107
108	Unit cost multiplier (Wkst. B, Part III)											108

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COST ALLOCATION - STATISTICAL BASIS					PROVIDER NO. 420087		PERIOD: FROM 01/01/2010 TO 12/31/2010		WORKSHEET B-1		
	COST CENTER DESCRIPTIONS	Other General Service (Specify)	Non-Physician Anesthetists (Assigned Time)	Nursing School (Assigned time)	Salary and Fringes (Assigned Time)	Program Costs (Assigned Time)	Paramedical Educ. Program (Assigned Time)	Subtotal	Intern & Resident Cost and Post Stepdown Adjustment	Total	
		19	20	21	22	23	24	25	26	27	
	GENERAL SERVICE COST CENTERS										
1	Old Capital Related Costs-Buildings and Fixtures										1
2	Old Capital Related Costs-Movable Equipment										2
3	New Capital Related Costs-Buildings and Fixtures										3
4	New Capital Related Costs-Movable Equipment										4
5	Employee Benefits										5
6.15	Other Administrative & General										6.15
7	Maintenance and Repairs										7
8	Operation of Plant										8
9	Laundry and Linen Service										9
10	Housekeeping										10
11	Dietary										11
12	Cafeteria										12
13	Maintenance of Personnel										13
14	Nursing Administration										14
15	Central Services and Supply										15
16	Pharmacy										16
17	Medical Records & Medical Records Library										17
18	Social Service										18
19.00	Other General Service (specify)										19.00
20	Nonphysician Anesthetists										20
21	Nursing School										21
22	Intern & Res. Service-Salary & Fringes (Approved)										22
23	Intern & Res. Other Program Costs (Approved)										23
24	Paramedical Education Program (specify)						4,701				24
	INPATIENT ROUTINE SERVICE COST CENTERS										
25	Adults and Pediatrics (General Routine Care)						2,682				25
26	Intensive Care Unit						659				26

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COST ALLOCATION - STATISTICAL BASIS					PROVIDER NO. 420087		PERIOD: FROM 01/01/2010 TO 12/31/2010		WORKSHEET B-1		
COST CENTER DESCRIPTIONS		Other General Service (Specify)	Non-Physician Anesthetists (Assigned time)	Nursing School (Assigned time)	Salary and Fringes (Assigned Time)	Program Costs (Assigned Time)	Paramedical Educ. Program (Assigned Time)	Subtotal	Intern & Resident Cost and Post Stepdown Adjustment	Total	
		19	20	21	22	23	24	25	26	27	
27	Coronary Care Unit										27
28	Burn Intensive Care Unit										28
29	Surgical Intensive Care Unit										29
30 00	Other Special Care (specify)										30 00
31.00	SubComponent 1 - 42T087						353				31.00
33	Nursery										33
34	Skilled Nursing Facility										34
35.00	Nursing Facility										35 00
36	Other Long Term Care										36
	ANCILLARY SERVICE COST CENTERS										
37.05	Operating Room						559				37.05
38	Recovery Room						110				38
39.05	Delivery Room & Labor Room						37				39.05
40.00	Anesthesiology										40.00
41.05	Radiology-Diagnostic										41.05
42.05	Radiology-Therapeutic						147				42.05
43	Radioisotope										43
44.05	Laboratory										44.05
44.45	Vascular Lab										44.45
45	PBP Clinical Laboratory Services-Program Only										45
46 00	Whole Blood & Packed Red Blood Cells										46 00
47	Blood Storing, Processing, & Trans.										47
48	Intravenous Therapy										48
49 05	Respiratory Therapy										49.05
50 05	Physical Therapy										50.05
51	Occupational Therapy										51
52	Speech Pathology										52
53.05	Electrocardiology										53 05
53 40	Cardiac Catheterization Laboratory										53.40
54	Electroencephalography										54

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COST ALLOCATION - STATISTICAL BASIS					PROVIDER NO. 420087		PERIOD: FROM 01/01/2010 TO 12/31/2010		WORKSHEET B-1		
COST CENTER DESCRIPTIONS		Other General Service (Specify)	Non-Physician Anesthetists (Assigned Time)	Nursing School (Assigned time)	Salary and Fringes (Assigned Time)	Program Costs (Assigned Time)	Paramedical Educ Program (Assigned Time)	Subtotal	Intern & Resident Cost and Post Stepdown Adjustment	Total	
		19	20	21	22	23	24	25	26	27	
55	Medical Supplies Charged to Patients										55
55.30	Implantable Devices Charged to Patients										55.30
56	Drugs Charged to Patients										56
57	Renal Dialysis										57
58	ASC (Non-Distinct Part)										58
59.30	Other Ancillary Cost Centers										59.30
	OUTPATIENT SERVICE COST CENTERS										
60.00	Clinic										60.00
61	Emergency						150				61
62.00	Observation Beds										
63.00	Other Outpatient Service (specify)										63.00
	OTHER REIMBURSABLE COST CENTERS										
64	Home Program Dialysis										64
65	Ambulance Services										65
66.00	Durable Medical Equipment-Rented										66.00
67.00	Durable Medical Equipment-Sold										67.00
68	Other Reimbursable (specify)										68
69.00	Outpatient Rehabilitation Provider (specify)										69.00
70	Intern-Resident Service (not appvd. tchng. pgm.)										70
71	Home Health Agency										71
	SPECIAL PURPOSE COST CENTERS										
82	Lung Acquisition										82
83	Kidney Acquisition										83
84	Liver Acquisition										84
85.00	Heart Acquisition										85.00
86	Other Organ Acquisition (specify)										86
92	Ambulatory Surgical Center (Distinct Part)										92
93	Hospice										93
94	Other Special Purpose (specify)										94
95	SUBTOTALS (sum of lines 1-94)						4,701				95

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COST ALLOCATION - STATISTICAL BASIS					PROVIDER NO. 420087		PERIOD FROM 01/01/2010 TO 12/31/2010		WORKSHEET B-1		
COST CENTER DESCRIPTIONS		Other General Service (Specify)	Non-Physician Anesthetists (Assigned Time)	Nursing School (Assigned time)	Salary and Fringes (Assigned Time)	Program Costs (Assigned Time)	Paramedical Educ Program (Assigned Time)	Subtotal	Intern & Resident Cost and Post Stepdown Adjustment	Total	
		19	20	21	22	23	24	25	26	27	
	NONREIMBURSABLE COST CENTERS										
96	Gift, Flower, Coffee Shop, & Canteen										96
97	Research										97
98	Physicians' Private Offices										98
99	Nonpaid Workers										99
100	Other Nonreimbursable (specify)										100
101	Cross foot adjustments										101
102	Negative cost centers										102
103	Cost to be allocated (per Wkst B, Part I)						283,457				103
104	Unit cost multiplier (Wkst. B, Part I)						60.297173				104
105	Cost to be allocated (per Wkst. B, Part II)										105
106	Unit cost multiplier (Wkst. B, Part II)										106
107	Cost to be allocated (per Wkst. B, Part III)										107
108	Unit cost multiplier (Wkst. B, Part III)										108

*Please note that CostReportData.com worksheets are replicated from electronic cost report data obtained from the CMS Healthcare Cost Report Information System dataset (HCRIS) and may differ from the format submitted by the hospital (e.g. sub-lines and sub-columns may be combined, certain totals have been calculated, etc.).

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ROPER HOSPITAL - CHARLESTON, SC
Cost report status - As Submitted
[Record code 268372 - 1996]

COMPUTATION OF RATIO OF COSTS TO CHARGES					PROVIDER NO: 420087			PERIOD: FROM 01/01/2010 TO 12/31/2010			WORKSHEET C, PART I	
	COST CENTER DESCRIPTIONS	Total Cost from Wkst B,Part I col 27	Therapy Limit Adj.	Total Costs	RCE Dis-allowance	Total Costs	Inpatient Charges	Outpatient Charges	Total Charges (col 6 + col 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		1	2	3	4	5	6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS												
25	Adults and Pediatrics (General Routine Care)	70,640,290		70,640,290		70,640,290	98,160,142		98,160,142				25
26	Intensive Care Unit	15,644,134		15,644,134		15,644,134	29,680,309		29,680,309				26
27	Coronary Care Unit												27
28	Burn Intensive Care Unit												28
29	Surgical Intensive Care Unit												29
30 00	Other Special Care (specify)												30.00
31 00	SubComponent 1 - 42T087	12,517,253		12,517,253		12,517,253	19,299,527		19,299,527				31.00
33	Nursery	1,705,386		1,705,386		1,705,386	1,601,444		1,601,444				33
34	Skilled Nursing Facility												34
35.00	Nursing Facility												35.00
36	Other Long Term Care												36
	ANCILLARY SERVICE COST CENTERS												
37.05	Operating Room	44,680,257		44,680,257		44,680,257	88,329,345	94,216,992	182,546,337	0.244761	0.244761	0.244761	37.05
38	Recovery Room	4,783,420		4,783,420		4,783,420	6,374,726	13,437,029	19,811,755	0.241444	0.241444	0.241444	38
39.05	Delivery Room & Labor Room	2,562,117		2,562,117		2,562,117	3,775,993	396,936	4,172,929	0 613985	0 613985	0.613985	39.05
40.00	Anesthesiology												40.00
41.05	Radiology-Diagnostic	24,618,205		24,618,205		24,618,205	31,843,446	150,327,852	182,171,298	0.135138	0.135138	0.135138	41.05
42 05	Radiology-Therapeutic	11,550,146		11,550,146		11,550,146	2,943,855	48,297,937	51,241,792	0 225405	0 225405	0.225405	42.05
43	Radioisotope												43
44.05	Laboratory	16,371,983		16,371,983		16,371,983	74,047,459	56,478,629	130,526,088	0.125431	0.125431	0.125431	44.05
44.45	Vascular Lab	3,720,744		3,720,744		3,720,744	4,650,389	12,155,072	16,805,461	0.221401	0.221401	0.221401	44.45
45	PBP Clinical Laboratory Services-Prgm Only												45
46 00	Whole Blood & Packed Red Blood Cells												46.00
47	Blood Storing, Processing, & Trans	4,731,536		4,731,536		4,731,536	16,182,824	3,801,189	19,984,013	0.236766	0.236766	0.236766	47
48	Intravenous Therapy												48
49 05	Respiratory Therapy	4,957,112		4,957,112		4,957,112	10,190,373	4,519,387	14,709,760	0.336995	0 336995	0.336995	49.05
50 05	Physical Therapy	6,616,580		6,616,580		6,616,580	21,190,210	3,708,350	24,898,560	0.265741	0 265741	0.265741	50.05
51	Occupational Therapy												51

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COMPUTATION OF RATIO OF COSTS TO CHARGES						PROVIDER NO: 420087			PERIOD: FROM 01/01/2010 TO 12/31/2010			WORKSHEET C, PART I	
	COST CENTER DESCRIPTIONS	Total Cost from Wksht B,Part I col 27	Therapy Limit Adj.	Total Costs	RCE Dis-allowance	Total Costs	Inpatient Charges	Outpatient Charges	Total Charges (col 6 + col 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		1	2	3	4	5	6	7	8	9	10	11	
52	Speech Pathology												52
53 05	Electrocardiology	1,686,501		1,686,501		1,686,501	9,083,446	6,713,574	15,797,020	0.106761	0 106761	0.106761	53.05
53 40	Cardiac Catheterization Laboratory	7,570,419		7,570,419		7,570,419	26,260,468	36,527,574	62,788,042	0 120571	0 120571	0.120571	53.40
54	Electroencephalography												54
55	Medical Supplies Charged to Patients												55
55.30	Implantable Devices Charged to Patients	30,168,695		30,168,695		30,168,695	46,747,754	30,110,965	76,858,719	0.392521	0 392521	0.392521	55.30
56	Drugs Charged to Patients	32,719,164		32,719,164		32,719,164	66,481,963	46,827,372	113,309,335	0.288760	0.288760	0.288760	56
57	Renal Dialysis												57
58	ASC (Non-Distinct Part)												58
59.30	Other Ancillary Cost Centers	1,699,651		1,699,651		1,699,651	905,278	98,189	1,003,467	1.693779	1 693779	1.693779	59.30
OUTPATIENT SERVICE COST CENTERS													
60.00	Clinic												60.00
61	Emergency	16,035,365		16,035,365		16,035,365	18,991,372	72,965,630	91,957,002	0 174379	0 174379	0.174379	61
62.10	Observation Beds (Non-DistinctPart)	2,803,112		2,803,112		2,803,112		3,600,843	3,600,843	0.778460	0 778460	0.778460	62.10
63.00	Other Outpatient Service (specify)												63.00
OTHER REIMBURSABLE COST CENTERS													
64	Home Program Dialysis												64
65	Ambulance Services	2,344,554		2,344,554		2,344,554	1,594,520	2,462,973	4,057,493	0.577833	0 577833	0.577833	65
66.00	Durable Medical Equipment-Rented												66.00
67 00	Durable Medical Equipment-Sold												67.00
68	Other Reimbursable (specify)												68
101	Subtotal (sum of lines 25 thru 68)	320,126,624		320,126,624		320,126,624	578,334,843	586,646,493	1,164,981,336				101
102	Less Observation Beds	2,803,112		2,803,112		2,803,112							102
103	Total (line 101 minus line 102)	317,323,512		317,323,512		317,323,512	578,334,843	586,646,493	1,164,981,336				103

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ROPER HOSPITAL - CHARLESTON, SC
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CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS						PROVIDER NO. 420087		PERIOD. FROM 01/01/2010 TO 12/31/2010		WORKSHEET C, PART II	
	Cost Center Descriptions	Total Cost (Wkst. B, Part I, col. 27)	Capital Cost (Wkst. B, sum of Parts II & III, col 27)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	Cost Net of Capital and Operating Cost Reduction	Total Charges (Wkst. C, Part I, col. 8)	Outpatient Cost to Charge Ratio (col. 6 ÷ col 7)	I/P Part B Cost to Charge Ratio (see instruc.)	
		1	2	3	4	5	6	7	8	9	
	ANCILLARY SERVICE COST CENTERS										
37.05	Operating Room	44,680,257	44,680,257					182,546,337		0.244761	37.05
38	Recovery Room	4,783,420	4,783,420					19,811,755		0.241444	38
39.05	Delivery Room & Labor Room	2,562,117	2,562,117					4,172,929		0.613985	39.05
40.00	Anesthesiology										40.00
41.05	Radiology-Diagnostic	24,618,205	24,618,205					182,171,298		0.135138	41.05
42.05	Radiology-Therapeutic	11,550,146	11,550,146					51,241,792		0.225405	42.05
43	Radioisotope										43
44.05	Laboratory	16,371,983	16,371,983					130,526,088		0.125431	44.05
44.45	Vascular Lab	3,720,744	3,720,744					16,805,461		0.221401	44.45
45	PBP Clinical Laboratory Services-Prgm. Only										45
46.00	Whole Blood & Packed Red Blood Cells										46.00
47	Blood Storing, Processing, & Trans.	4,731,536	4,731,536					19,984,013		0.236766	47
48	Intravenous Therapy										48
49.05	Respiratory Therapy	4,957,112	4,957,112					14,709,760		0.336995	49.05
50.05	Physical Therapy	6,616,580	6,616,580					24,898,560		0.265741	50.05
51	Occupational Therapy										51
52	Speech Pathology										52
53.05	Electrocardiology	1,686,501	1,686,501					15,797,020		0.106761	53.05
53.40	Cardiac Catheterization Laboratory	7,570,419	7,570,419					62,788,042		0.120571	53.40
54	Electroencephalography										54
55	Medical Supplies Charged to Patients										55
56	Drugs Charged to Patients	32,719,164	32,719,164					113,309,335		0.288760	56
57	Renal Dialysis										57
58	ASC (Non-Distinct Part)										58
59.30	Other Ancillary Cost Centers	1,699,651	1,699,651					1,003,467		1.693779	59.30
60.00	Clinic										60.00
61	Emergency	16,035,365	16,035,365					91,957,002		0.174379	61
62.10	Observation Beds (Non-DistinctPart)							3,600,843			62.10

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CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS						PROVIDER NO. 420087		PERIOD: FROM 01/01/2010 TO 12/31/2010		WORKSHEET C, PART II	
	Cost Center Descriptions	Total Cost (Wkst. B, Part I, col. 27)	Capital Cost (Wkst. B, sum of Parts II & III, col. 27)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operatmg Cost Reduction Amount	Cost Net of Capital and Operating Cost Reduction	Total Charges (Wkst. C, Part I, col. 8)	Outpatient Cost to Charge Ratio (col. 6 + col 7)	I/P Part B Cost to Charge Ratio (see instruc.)	
		1	2	3	4	5	6	7	8	9	
63.00	Other Outpatient Service (specify)										63 00
	OTHER REIMBURSABLE COST CENTERS										
64	Home Program Dialysis										64
65	Ambulance Services	2,344,554	2,344,554					4,057,493		0.577833	65
66	Durable Medical Equipment - Rented										66
67	Durable Medical Equipment - Sold										67
68	Other Reimbursable (specify)										68
101	Subtotal (sum of lines 37-68)							1,164,981,336			101
102	Less Observation Beds										102
103	Total (sum of line 101 minus line 102)	332,078,318						1,164,981,336			103

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ROPER HOSPITAL - CHARLESTON, SC
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS	PROVIDER NO. 420087	PERIOD: FROM. 01/01/2010 TO: 12/31/2010	WORKSHEET D, PART I

Medicare -Title XVIII - Hospital - 420087

	Cost Center Description	Old Capital			New Capital					Old Capital		New Capital		
		Capital Related Cost (from Wkst. B, Part II, col. 27)	Swing Bed Adj.	Reduced Capital Related Cost (col. 1 - col. 2)	Capital Related Cost (from Wkst. B, Part III, col. 27)	Swing Bed Adj.	Reduced Capital Related Cost (col. 4 - col. 5)	Total Patient Days	Inpatient Program Days	Per Diem (col. 3 ÷ col. 7)	Inpatient Program Capital Cost (col. 9 x col. 8)	Per Diem (col. 6 ÷ col. 7)	Inpatient Program Capital Cost (col. 11 x col. 8)	
		1	2	3	4	5	6	7	8	9	10	11	12	
(A)	INPATIENT ROUTINE SERVICE COST CENTERS													
25	Adults & Pediatrics (General Routine Care)				11,001,916		11,001,916	65,522	34,795			167.91	5,842,428	25
26	Intensive Care Unit				2,151,604		2,151,604	8,753	5,126			245.81	1,260,022	26
27	Coronary Care Unit													27
28	Burn Intensive Care Unit													28
29	Surgical Intensive Care Unit													29
30.00	Other Special Care (specify)													30.00
31.00	SubComponent 1 - 42T087				1,831,334		1,831,334	14,038	8,693			130.46	1,134,089	31.00
33	Nursery				140,627		140,627	1,354				103.86		33
101	Total (lines 25-33)				15,125,481		15,125,481	89,667	48,614				8,236,539	101

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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	PROVIDER NO: 420087	PERIOD: FROM: 01/01/2010 TO: 12/31/2010	WORKSHEET D, PART II

Medicare - Title XVIII - Hospital - 420087

		Old Capital Related Cost (from Wkst. B, Part II, col. 27)	New Capital Related Cost (from Wkst. B, Part III, col. 27)	Total Charges (from Wkst. C, Part I, col. 8)	Inpatient Program Charges	Old Capital		New Capital		
						Ratio of Cost to Charges (col. 1 ÷ col. 3)	Capital Costs (col. 4 x col. 5)	Ratio of Cost to Charges (col. 2 ÷ col. 3)	Capital Costs (col. 4 x col. 7)	
Cost Center Description		1	2	3	4	5	6	7	8	
(A)	ANCILLARY SERVICE COST CENTERS									
37.05	Operating Room		7,082,326	182,546,337	42,792,903			0.038797	1,660,236	37.05
38	Recovery Room		383,278	19,811,755	3,053,608			0.019346	59,075	38
39.05	Delivery Room & Labor Room		546,942	4,172,929	27,358			0.131069	3,586	39.05
40.00	Anesthesiology									40.00
41.05	Radiology-Diagnostic		4,757,317	182,171,298	18,309,521			0.026115	478,153	41.05
42.05	Radiology-Therapeutic		2,795,427	51,241,792	1,400,465			0.054554	76,401	42.05
43	Radioisotope									43
44.05	Laboratory		1,540,725	130,526,088	42,082,785			0.011804	496,745	44.05
44.45	Vascular Lab		1,021,213	16,805,461	2,384,885			0.060767	144,922	44.45
45	PBP Clinical Laboratory Services-Prgm. Only									45
46.00	Whole Blood & Packed Red Blood Cells									46.00
47	Blood Storing, Processing, & Transfusing		176,453	19,984,013	9,123,040			0.008830	80,556	47
48	Intravenous Therapy									48
49.05	Respiratory Therapy		458,073	14,709,760	6,414,514			0.031141	199,754	49.05
50.05	Physical Therapy		667,693	24,898,560	4,755,498			0.026817	127,528	50.05
51	Occupational Therapy									51
52	Speech Pathology									52
53.05	Electrocardiology		431,098	15,797,020	5,641,051			0.027290	153,944	53.05
53.40	Cardiac Catheterization Laboratory		1,489,651	62,788,042	14,899,552			0.023725	353,492	53.40
54	Electroencephalography									54
55	Medical Supplies Charged to Patients									55
55.30	Implantable Devices Charged to Patients		281,254	76,858,719	24,834,448			0.003659	90,869	55.30
56	Drugs Charged to Patients		745,858	113,309,335	33,640,247			0.006582	221,420	56
57	Renal Dialysis									57
58	ASC (Non-Distinct Part)									58
59.30	Other Ancillary Cost Centers		176,007	1,003,467	612,474			0.175399	101,965	59.30

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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	PROVIDER NO: 420087	PERIOD: FROM: 01/01/2010 TO: 12/31/2010	WORKSHEET D, PART II

Medicare -Title XVIII - Hospital - 420087

		Old Capital Related Cost (from Wkst. B, Part II, col 27)	New Capital Related Cost (from Wkst. B, Part III, col 27)	Total Charges (from Wkst. C, Part I, col. 8)	Inpatient Program Charges	Old Capital		New Capital		
						Ratio of Cost to Charges (col 1 ÷ col. 3)	Capital Costs (col 4 x col. 5)	Ratio of Cost to Charges (col. 2 ÷ col. 3)	Capital Costs (col. 4 x col. 7)	
Cost Center Description		1	2	3	4	5	6	7	8	
60.00	Clinic									60.00
61	Emergency		1,744,660	91,957,002	11,046,134			0.018973	209,578	61
62 10	Observation Beds (Non-DistinctPart)			3,600,843						62 10
63.00	Other Outpatient Service (specify)									63.00
	OTHER REIMBURSABLE COST CENTERS									
64	Home Program Dialysis									64
65	Ambulance Services									65
66 00	Durable Medical Equipment-Rented									66.00
67.00	Durable Medical Equipment-Sold									67.00
68	Other Reimbursable (specify)									68
101	Total (sum of lines 37 through 68)		24,297.975	1,012,182,421	221,018,483				4,458,224	101

(A) Worksheet A line numbers -

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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	PROVIDER NO: 420087	PERIOD: FROM: 01/01/2010 TO: 12/31/2010	WORKSHEET D, PART II

Medicare - Title XVIII - Subprovider 1 - 42T087

	Cost Center Description	Old Capital Related Cost (from Wkst. B, Part II, col. 27)	New Capital Related Cost (from Wkst. B, Part III, col. 27)	Total Charges (from Wkst. C, Part I, col. 8)	Inpatient Program Charges	Old Capital: Ratio of Cost to Charges (col. 1 ÷ col. 3)	Old Capital: Capital Costs (col. 4 x col. 5)	New Capital: Ratio of Cost to Charges (col. 2 ÷ col. 3)	New Capital: Capital Costs (col. 4 x col. 7)	
		1	2	3	4	5	6	7	8	
(A)	ANCILLARY SERVICE COST CENTERS									
37.05	Operating Room		7,082,326	182,546,337	243,091			0.038797	9,431	37.05
38	Recovery Room		383,278	19,811,755	18,278			0.019346	354	38
39.05	Delivery Room & Labor Room		546,942	4,172,929				0.131069		39 05
40.00	Anesthesiology									40 00
41.05	Radiology-Diagnostic		4,757,317	182,171,298	541,150			0.026115	14,132	41.05
42.05	Radiology-Therapeutic		2,795,427	51,241,792	17,478			0.054554	953	42.05
43	Radioisotope									43
44 05	Laboratory		1,540,725	130,526,088	2,381,163			0.011804	28,107	44 05
44.45	Vascular Lab		1,021,213	16,805,461	746,822			0.060767	45,382	44 45
45	PBP Clinical Laboratory Services-Prgm. Only									45
46.00	Whole Blood & Packed Red Blood Cells									46.00
47	Blood Storing, Processing, & Transfusing		176,453	19,984,013	70,117			0.008830	619	47
48	Intravenous Therapy									48
49.05	Respiratory Therapy		458,073	14,709,760	272,880			0.031141	8,498	49.05
50 05	Physical Therapy		667,693	24,898,560	9,697,037			0.026817	260,045	50 05
51	Occupational Therapy									51
52	Speech Pathology									52
53.05	Electrocardiology		431,098	15,797,020	82,729			0.027290	2,258	53.05
53.40	Cardiac Catheterization Laboratory		1,489,651	62,788,042				0 023725		53 40
54	Electroencephalography									54
55	Medical Supplies Charged to Patients									55
55.30	Implantable Devices Charged to Patients		281,254	76,858,719	52,950			0.003659	194	55.30
56	Drugs Charged to Patients		745,858	113,309,335	2,127,859			0.006582	14,006	56
57	Renal Dialysis									57
58	ASC (Non-Distinct Part)									58
59.30	Other Ancillary Cost Centers		176,007	1,003,467	20,237			0.175399	4,378	59.30

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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	PROVIDER NO: 420087	PERIOD: FROM: 01/01/2010 TO: 12/31/2010	WORKSHEET D, PART II

Medicare - Title XVIII - Subprovider 1 - 4ZT087

	Cost Center Description	Old Capital Related Cost (from Wkst. B, Part II, col. 27)	New Capital Related Cost (from Wkst. B, Part III, col 27)	Total Charges (from Wkst. C, Part 1, col. 8)	Inpatient Program Charges	Old Capital: Ratio of Cost to Charges (col 1 ÷ col. 3)	Old Capital: Capital Costs (col. 4 x col 5)	New Capital: Ratio of Cost to Charges (col. 2 ÷ col. 3)	New Capital: Capital Costs (col. 4 x col. 7)	
		1	2	3	4	5	6	7	8	
60.00	Clinic									60.00
61	Emergency		1,744,660	91,957,002				0.018973		61
62.10	Observation Beds (Non-DistinctPart)			3,600,843						62.10
63.00	Other Outpatient Service (specify)									63.00
	OTHER REIMBURSABLE COST CENTERS									
64	Home Program Dialysis									64
65	Ambulance Services									65
66.00	Durable Medical Equipment-Rented									66.00
67.00	Durable Medical Equipment-Sold									67.00
68	Other Reimbursable (specify)									68
101	Total (sum of lines 37 through 68)		24,297,975	1,012,182,421	16,271,791				388,357	101

(A) Worksheet A line numbers

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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	PROVIDER NO: 420087	PERIOD: FROM: 01/01/2010 TO: 12/31/2010	WORKSHEET D, PART III

Medicare - Title XVIII - Hospital - 420087

	Cost Center Description	Nonphysician Anesthetist Cost	Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Tota Costs (sum of cols. 1 + 2, minus col. 3)	Total Patient Days	Per Diem (col. 4 ÷ col. 5)	Inpatient Program Days	Inpatient Program Pass thru Cost (col 6 x col. 7)	
		1	2	3	4	5	6	7	8	
(A)	INPATIENT ROUTINE SERVICE COST CENTERS									
25	Adults & Pediatrics (General Routine Care)		161,777		161,777	65,522	2.47	34,795	85,944	25
26	Intensive Care Unit		39,736		39,736	8,753	4.54	5,126	23,272	26
27	Coronary Care Unit									27
28	Burn Intensive Care Unit									28
29	Surgical Intensive Care Unit									29
30.00	Other Special Care (specify)									30.00
31 00	SubComponent 1 - 42T087		21,345		21,345	14,038	1.52	8,693	13,213	31 00
33	Nursery					1,354				33
34	Skilled Nursing Facility									34
35 00	Nursing Facility									35 00
101	Total (sum of lines 25-35)		222,858		222,858	89,667		48,614	122,429	101

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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	PROVIDER NO: 420087	PERIOD: FROM: 01/01/2010 TO: 12/31/2010	WORKSHEET D, PART III

Medicaid - Title XIX - Hospital - 420087

	Cost Center Description	Nonphysician Anesthetist Cost	Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Tota Costs (sum of cols. 1 + 2, minus col. 3)	Total Patient Days	Per Diem (col. 4 ÷ col. 5)	Inpatient Program Days	Inpatient Program Pass thru Cost (col. 6 x col. 7)	
		1	2	3	4	5	6	7	8	
(A)	INPATIENT ROUTINE SERVICE COST CENTERS									
25	Adults & Pediatrics (General Routine Care)									25
26	Intensive Care Unit									26
27	Coronary Care Unit									27
28	Burn Intensive Care Unit									28
29	Surgical Intensive Care Unit									29
30.00	Other Special Care (specify)									30.00
31.00	SubComponent 1 - 42T087									31.00
33	Nursery									33
34	Skilled Nursing Facility									34
35.00	Nursing Facility									35.00
101	Total (sum of lines 25-35)								8,767	101

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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	PROVIDER NO: 420087	PERIOD: FROM: 01/01/2010 TO: 12/31/2010	WORKSHEET D, PART IV

Medicare -Title XVIII - Hospital - 420087

	Cost Center Description	Nonphysician Anesthetist Cost	Medical Education Cost	Total Costs (col. 1 + col. 2)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col 3 ÷ col. 4)	Inpatient Program Charges	Inpatient Program Pass Through Costs (col. 5 × col. 6)	Outpatient Program Charges	Outpatient Program Pass Through Costs (col. 5 × col. 8)	
		1	2	3	4	5	6	7	8	9	
(A)	ANCILLARY SERVICE COST CENTERS										
37.05	Operating Room		33,766	33,766	182,546,337	0.000185	42,792,903	7,917	23,766,860	4,397	37.05
38	Recovery Room		6,633	6,633	19,811,755	0.000335	3,053,608	1,023	3,424,665	1,147	38
39.05	Delivery Room & Labor Room		2,291	2,291	4,172,929	0.000549	27,358	15	7,905	4	39.05
40.00	Anesthesiology										40.00
41.05	Radiology-Diagnostic				182,171,298		18,309,521		53,904,110		41.05
42.05	Radiology-Therapeutic		8,864	8,864	51,241,792	0.000173	1,400,465	242	19,468,159	3,368	42.05
43	Radioisotope										43
44.05	Laboratory				130,526,088		42,082,785		18,879,002		44.05
44.45	Vascular Lab				16,805,461		2,384,885		5,714,741		44.45
45	PBP Clinical Laboratory Services-Prgm Only										45
46.00	Whole Blood & Packed Red Blood Cells										46.00
47	Blood Storing, Processing, & Transfusing				19,984,013		9,123,040		1,971,540		47
48	Intravenous Therapy										48
49.05	Respiratory Therapy				14,709,760		6,414,514		1,450,265		49.05
50.05	Physical Therapy				24,898,560		4,755,498		1,059,526		50.05
51	Occupational Therapy										51
52	Speech Pathology										52
53.05	Electrocardiology				15,797,020		5,641,051		2,823,607		53.05
53.40	Cardiac Catheterization Laboratory				62,788,042		14,899,552		18,178,318		53.40
54	Electroencephalography										54
55	Medical Supplies Charged to Patients										55
55.30	Implantable Devices Charged to Patients						24,834,448		13,542,161		55.30
56	Drugs Charged to Patients				113,309,335		33,640,247		16,964,233		56
57	Renal Dialysis										57
58	ASC (Non-Distinct Part)										58
59.30	Other Ancillary Cost Centers				1,003,467		612,474		61,615		59.30
	OUTPATIENT SERVICE COST CENTERS										
60.00	Clinic										60.00
61	Emergency		9,045	9,045	91,957,002	0.000098	11,046,134	1,083	13,801,873	1,353	61
62.10	Observation Beds (Non-DistinctPart)		6,419	6,419	3,600,843	0.001783			1,296,110	2,311	62.10
63.00	Other Outpatient Service (specify)										63.00
	OTHER REIMBURSABLE COST CENTERS										

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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	PROVIDER NO: 420087	PERIOD: FROM: 01/01/2010 TO: 12/31/2010	WORKSHEET D, PART IV

Medicare - Title XVIII - Hospital - 420087

	Cost Center Description	Nonphysician Anesthetist Cost	Medical Education Cost	Total Costs (col. 1 + col. 2)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 3 ÷ col. 4)	Inpatient Program Charges	Inpatient Program Pass Through Costs (col. 5 × col. 6)	Outpatient Program Charges	Outpatient Program Pass Through Costs (col. 5 × col. 8)	
		1	2	3	4	5	6	7	8	9	
64	Home Program Dialysis										64
65	Ambulance Services	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]			65
66.00	Durable Medical Equipment-Rented										66.00
67.00	Durable Medical Equipment-Sold										67.00
68	Other Reimbursable (specify)										68
101	Total (sum of lines 37 through 68)		67,018	67,018	935,323,702	[redacted]	221,018,483	10,280	196,314,690	12,580	101

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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	PROVIDER NO 420087	PERIOD. FROM: 01/01/2010 TO: 12/31/2010	WORKSHEET D, PART IV

Medicare - Title XVIII - Subprovider 1 - 42T087

	Cost Center Description	Nonphysician Anesthetist Cost	Medical Education Cost	Total Costs (col. 1 + col. 2)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 3 ÷ col. 4)	Inpatient Program Charges	Inpatient Program Pass Through Costs (col. 5 × col. 6)	Outpatient Program Charges	Outpatient Program Pass Through Costs (col. 5 × col. 8)	
		1	2	3	4	5	6	7	8	9	
(A)	ANCILLARY SERVICE COST CENTERS										
37.05	Operating Room		33,766	33,766	182,546,337	0.000185	243,091	45			37.05
38	Recovery Room		6,633	6,633	19,811,755	0.000335	18,278	6			38
39.05	Delivery Room & Labor Room		2,291	2,291	4,172,929	0.000549					39.05
40.00	Anesthesiology										40.00
41.05	Radiology-Diagnostic				182,171,298		541,150		2,183		41.05
42.05	Radiology-Therapeutic		8,864	8,864	51,241,792	0.000173	17,478	3			42.05
43	Radioisotope										43
44.05	Laboratory				130,526,088		2,381,163				44.05
44.45	Vascular Lab				16,805,461		746,822		1,617		44.45
45	PRP Clinical Laboratory Services-Prgm. Only										45
46.00	Whole Blood & Packed Red Blood Cells										46.00
47	Blood Storing, Processing, & Transfusing				19,984,013		70,117				47
48	Intravenous Therapy										48
49.05	Respiratory Therapy				14,709,760		272,880				49.05
50.05	Physical Therapy				24,898,560		9,697,037				50.05
51	Occupational Therapy										51
52	Speech Pathology										52
53.05	Electrocardiology				15,797,020		82,729				53.05
53.40	Cardiac Catheterization Laboratory				62,788,042						53.40
54	Electroencephalography										54
55	Medical Supplies Charged to Patients										55
55.30	Implantable Devices Charged to Patients						52,950				55.30
56	Drugs Charged to Patients				113,309,335		2,127,859				56
57	Renal Dialysis										57
58	ASC (Non-Distinct Part)										58
59.30	Other Ancillary Cost Centers				1,003,467		20,237				59.30
	OUTPATIENT SERVICE COST CENTERS										
60.00	Clinic										60.00
61	Emergency		9,045	9,045	91,957,002	0.000098					61
62.10	Observation Beds (Non-DistinctPart)		6,419	6,419	3,600,843	0.001783					62.10
63.00	Other Outpatient Service (specify)										63.00
	OTHER REIMBURSABLE COST CENTERS										

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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	PROVIDER NO: 420087	PERIOD: FROM: 01/01/2010 TO: 12/31/2010	WORKSHEET D, PART IV

Medicare -Title XVIII - Subprovider 1 - 42T087

	Cost Center Description	Nonphysician Anesthetist Cost	Medical Education Cost	Total Costs (col. 1 + col. 2)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 3 ÷ col. 4)	Inpatient Program Charges	Inpatient Program Pass Through Costs (col. 5 × col. 6)	Outpatient Program Charges	Outpatient Program Pass Through Costs (col. 5 × col. 8)	
		1	2	3	4	5	6	7	8	9	
64	Home Program Dialysis										64
65	Ambulance Services										65
66.00	Durable Medical Equipment-Rented										66.00
67.00	Durable Medical Equipment-Sold										67.00
68	Other Reimbursable (specify)										68
101	Total (sum of lines 37 through 68)		67,018	67,018	935,323,702		16,271,791	54	3,800		101

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APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	PROVIDER NO: 420087	PERIOD: FROM 01/01/2010 TO 12/31/2010	WORKSHEET D, PARTS V & VI

Medicare - Title XVIII - Hospital - 420087

PART V - APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

	Cost Center Description	Cost to Charge Ratio From Worksheet C			PROGRAM CHARGES						PROGRAM COSTS								
		Part II col. 8	Part I col. 9	Part II col. 9	Outpatient Ambulatory Surgical Center	Outpatient Radiology	Other Outpatient Diagnostic	All Other (1) (see instru.)	PPS services (see instru.)	All Other (see instru.)	Outpatient Ambulatory Surgical Center (cols 1 × 2)	Outpatient Radiology (cols. 1 × 3)	Other Outpatient Diagnostic (cols. 1 × 4)	All Other (cols. 1 × 5)	PPS services (columns 1.01 × 5.01)	All Other (columns 1.01 × 5.02)	Hospital I/P Part B Charges (see instru.)	Hospital I/P part B Cost (columns 1.02 × 10)	
		1	1.01	1.02	2	3	4	5	5.01	5.02	6	7	8	9	9.01	9.02	10	11	
	ANCILLARY SERVICE COST CENTERS																		
37.05	Operating Room		0.244761	0.244761					23,766,860						5,817,200				37.05
38	Recovery Room		0.241444	0.241444					3,424,665						826,865				38
39.05	Delivery Room & Labor Room		0.613985	0.613985					7,905						4,854				39.05
40.00	Anesthesiology																		40.00
41.05	Radiology-Diagnostic		0.135138	0.135138					53,904,110						7,284,494				41.05
42.05	Radiology-Therapeutic		0.225405	0.225405					19,468,159						4,388,220				42.05
43	Radioisotope																		43
44.05	Laboratory		0.125431	0.125431					18,879,002						2,368,012				44.05
44.45	Vascular Lab		0.221401	0.221401					5,714,741						1,265,249				44.45
45	PBP Clinic Laboratory Services-Prgm Only																		45
46.00	Whole Blood & Packed Red Blood Cells																		46.00
47	Blood Storing, Processing, & Transfusing		0.236766	0.236766					1,971,540						466,794				47
48	Intravenous Therapy																		48
49.05	Respiratory Therapy		0.336995	0.336995					1,450,265						488,732				49.05
50.05	Physical Therapy		0.265741	0.265741					1,059,526						281,559				50.05
51	Occupational Therapy																		51
52	Speech Pathology																		52
53.05	Electrocardiology		0.106761	0.106761					2,823,607						301,451				53.05
53.40	Cardiac Catheterization Laboratory		0.120571	0.120571					18,178,318						2,191,778				53.40
54	Electroencephalography																		54
55	Medical Supplies Charged To Patients																		55
55.30	Implantable Devices Charged to Patients								13,542,161						5,315,583				55.30
56	Drugs Charged To Patients		0.288760	0.288760					16,964,233						4,898,592				56
57	Renal Dialysis																		57
58	ASC (Non-Distinct Part)																		58
59.30	Other Ancillary Cost Centers		1.693779	1.693779					61,615						118,245				59.30

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APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	PROVIDER NO: 420087	PERIOD: FROM 01/01/2010 TO 12/31/2010	WORKSHEET D, PARTS V & VI

Medicare - Title XVIII - Hospital - 420087

PART V - APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

	Cost Center Description	Cost to Charge Ratio From Worksheet C			PROGRAM CHARGES						PROGRAM COSTS								
		Part II col 8	Part I col. 9	Part II col. 9	Outpatient Ambulatory Surgical Center	Outpatient Radiology	Other Outpatient Diagnostic	All Other (1) (see instru.)	PPS services (see instru.)	All Other (see instru.)	Outpatient Ambulatory Surgical Center (cols 1 × 2)	Outpatient Radiology (cols. 1 × 3)	Other Outpatient Diagnostic (cols 1 × 4)	All Other (cols 1 × 5)	PPS services (columns 1.01 × 5.01)	All Other (columns 1.01 × 5.02)	Hospital I/P Part B Charges (see instru.)	Hospital I/P part B Cost (columns 1.02 × 10)	
		1	1.01	1.02	2	3	4	5	5.01	5.02	6	7	8	9	9.01	9.02	10	11	
	OUTPATIENT SERVICE COST CENTERS																		
60.00	Clinic																		60.00
61	Emergency		0.174379	0.174379					13,801,873						2,406,757				61
62.10	Observation Beds (Non-DistinctPart)		0.778460						1,296.110						1,008,970				62.10
63.00	Other Outpatient Service (specify)																		63.00
	OTHER REIMBURSABLE COST CENTERS																		
64	Home Program Dialysis																		64
65	Ambulance		0.577833	0.577833															65
66.00	Durable Medical Equipment-Rented																		66.00
67.00	Durable Medical Equipment-Sold																		67.00
68	Other Reimbursable Cost Center																		68
101	Subtotal (see instructions)								196,314,690						39,433,355				101
102	CRNA Charges (see instructions)																		102
103	Less PBP Clinic Lab. Services-Program Only Charges																		103
104	Net Charges (line 101 + (lines 102 + 103)								196,314,690						39,433,355				104

PART VI - VACCINE COST APPORTIONMENT

		1	
1	Drugs charged to patients - ratio of cost to charges (from Worksheet C, Part I, column 9, line 56)		1
2	Program vaccine charges (from your records or the PS&R)		2
3	Program costs (line 1 × lines 2) (see instructions for transfer)		3
	(A) Worksheet A line numbers (1) Report non hospital and non subprovider components cost for the period here (see instructions)		

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APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	PROVIDER NO 420087	PERIOD: FROM 01/01/2010 TO 12/31/2010	WORKSHEET D, PARTS V & VI

Medicare -Title XVIII - Subprovider 1 - 42T087

PART V - APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

	Cost Center Description	Cost to Charge Ratio From Worksheet C			PROGRAM CHARGES						PROGRAM COSTS								
		Part II col 8	Part I col. 9	Part II col 9	Outpatient Ambulatory Surgical Center	Outpatient Radiology	Other Outpatient Diagnostic	All Other (1) (see instru.)	PPS services (see instru.)	All Other (see instru.)	Outpatient Ambulatory Surgical Center (cols 1 × 2)	Outpatient Radiology (cols. 1 × 3)	Other Outpatient Diagnostic (cols. 1 × 4)	All Other (cols. 1 × 5)	PPS services (columns 1.01 × 5.01)	All Other (columns 1.01 × 5.02)	Hospital I/P Part B Charges (see instru.)	Hospital I/P part B Cost (columns 1.02 × 10)	
		1	1.01	1.02	2	3	4	5	5.01	5.02	6	7	8	9	9.01	9.02	10	11	
	ANCILLARY SERVICE COST CENTERS																		
37.05	Operating Room		0.244761	0.244761															37.05
38	Recovery Room		0.241444	0.241444															38
39.05	Delivery Room & Labor Room		0.613985	0 613985															39.05
40.00	Anesthesiology																		40.00
41 05	Radiology-Diagnostic		0.135138	0 135138					2,183						295				41.05
42 05	Radiology-Therapeutic		0.225405	0 225405															42.05
43	Radioisotope																		43
44.05	Laboratory		0.125431	0.125431															44.05
44.45	Vascular Lab		0.221401	0 221401					1,617						358				44.45
45	PBP Clinic Laboratory Services-Prgm Only																		45
46.00	Whole Blood & Packed Red Blood Cells																		46.00
47	Blood Storing, Processing, & Transfusing		0.236766	0.236766															47
48	Intravenous Therapy																		48
49.05	Respiratory Therapy		0.336995	0 336995															49.05
50.05	Physical Therapy		0.265741	0.265741															50.05
51	Occupational Therapy																		51
52	Speech Pathology																		52
53.05	Electrocardiology		0.106761	0.106761															53.05
53.40	Cardiac Catheterization Laboratory		0.120571	0.120571															53 40
54	Electroencephalography																		54
55	Medical Supplies Charged To Patients																		55
55.30	Implantable Devices Charged to Patients																		55.30
56	Drugs Charged To Patients		0.288760	0.288760															56
57	Renal Dialysis																		57
58	ASC (Non-Distinct Part)																		58
59.30	Other Ancillary Cost Centers		1.693779	1.693779															59.30

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APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	PROVIDER NO: 420087	PERIOD: FROM 01/01/2010 TO 12/31/2010	WORKSHEET D, PARTS V & VI

Medicare -Title XVIII - Subprovider 1 - 42T087

PART V - APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

	Cost Center Description	Cost to Charge Ratio From Worksheet C			PROGRAM CHARGES						PROGRAM COSTS								
		Part II col 8	Part I col. 9	Part II col. 9	Outpatient Ambulatory Surgical Center	Outpatient Radiology	Other Outpatient Diagnostic	All Other (1) (see instru.)	PPS services (see instru.)	All Other (see instru.)	Outpatient Ambulatory Surgical Center (cols. 1 × 2)	Outpatient Radiology (cols. 1 × 3)	Other Outpatient Diagnostic (cols 1 × 4)	All Other (cols 1 × 5)	PPS services (columns 1.01 × 5.01)	All Other (columns 1.01 × 5.02)	Hospital I/P Part B Charges (see instru.)	Hospital I/P part B Cost (columns 1.02 × 10)	
		1	1.01	1.02	2	3	4	5	5.01	5.02	6	7	8	9	9.01	9.02	10	11	
	OUTPATIENT SERVICE COST CENTERS																		
60.00	Clinic																		60.00
61	Emergency		0.174379	0.174379															61
62.10	Observation Beds (Non-DistinctPart)		0.778460																62.10
63.00	Other Outpatient Service (specify)																		63.00
	OTHER REIMBURSABLE COST CENTERS																		
64	Home Program Dialysis																		64
65	Ambulance		0.577833	0.577833															65
66.00	Durable Medical Equipment-Rented																		66.00
67.00	Durable Medical Equipment-Sold																		67.00
68	Other Reimbursable Cost Center																		68
101	Subtotal (see instructions)								3,800						653				101
102	CRNA Charges (see instructions)																		102
103	Less PBP Clinic Lab. Services-Program Only Charges																		103
104	Net Charges (line 101 ± (lines 102 + 103)								3,800						653				104

PART VI - VACCINE COST APPORTIONMENT

		1	
1	Drugs charged to patients - ratio of cost to charges (from Worksheet C, Part I, column 9, line 56)		1
2	Program vaccine charges (from your records or the PS&R)		2
3	Program costs (line 1 × lines 2) (see instructions for transfer)		3
	(A) Worksheet A line numbers (1) Report non hospital and non subprovider components cost for the period here (see instructions)		

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ROPER HOSPITAL - CHARLESTON, SC
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APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	PROVIDER NO: 420087	PERIOD: FROM 01/01/2010 TO 12/31/2010	WORKSHEET D, PARTS V & VI

Medicaid - Title XIX - Hospital - 420087

PART V - APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

Cost Center Description	Cost to Charge Ratio From Worksheet C			PROGRAM CHARGES						PROGRAM COSTS								
	Part II col. 8	Part I col. 9	Part II col. 9	Outpatient Ambulatory Surgical Center	Outpatient Radiology	Other Outpatient Diagnostic	All Other (1) (see instru.)	PPS services (see instru.)	All Other (see instru.)	Outpatient Ambulatory Surgical Center (cols. 1 × 2)	Outpatient Radiology (cols. 1 × 3)	Other Outpatient Diagnostic (cols. 1 × 4)	All Other (cols. 1 × 5)	PPS services (columns 1.01 × 5.01)	All Other (columns 1.01 × 5.02)	Hospital I/P Part B Charges (see instru.)	Hospital I/P part B Cost (columns 1.02 × 10)	
	1	1.01	1.02	2	3	4	5	5.01	5.02	6	7	8	9	9.01	9.02	10	11	
ANCILLARY SERVICE COST CENTERS																		
37.05 Operating Room		0.244761	0.244761				1,490,487						341,226					37.05
38 Recovery Room		0.241444	0.241444				230,948						52,339					38
39.05 Delivery Room & Labor Room		0.613985	0.613985				95,943						54,963					39.05
40.00 Anesthesiology																		40.00
41.05 Radiology-Diagnostic		0.135138	0.135138				2,997,885						378,342					41.05
42.05 Radiology-Therapeutic		0.225405	0.225405				884,786						185,840					42.05
43 Radioisotope																		43
44.05 Laboratory		0.125431	0.125431				1,946,994						229,083					44.05
44.45 Vascular Lab		0.221401	0.221401				88,073						18,144					44.45
45 PBP Clinic Laboratory Services-Prgm Only																		45
46.00 Whole Blood & Packed Red Blood Cells																		46.00
47 Blood Storing, Processing, & Transfusing		0.236766	0.236766				87,612						19,508					47
48 Intravenous Therapy																		48
49.05 Respiratory Therapy		0.336995	0.336995				80,283						25,381					49.05
50.05 Physical Therapy		0.265741	0.265741				125,903						31,375					50.05
51 Occupational Therapy																		51
52 Speech Pathology																		52
53.05 Electrocardiology		0.106761	0.106761				64,858						6,448					53.05
53.40 Cardiac Catheterization Laboratory		0.120571	0.120571				296,465						33,376					53.40
54 Electroencephalography																		54
55 Medical Supplies Charged To Patients																		55
55.30 Implantable Devices Charged to Patients							271,053						100,182					55.30
56 Drugs Charged To Patients		0.288760	0.288760				2,665,985						724,441					56
57 Renal Dialysis																		57
58 ASC (Non-Distinct Part)																		58
59.30 Other Ancillary Cost Centers		1.693779	1.693779				1,056						1,899					59.30

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APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	PROVIDER NO: 420087	PERIOD: FROM 01/01/2010 TO 12/31/2010	WORKSHEET D, PARTS V & VI

Medicaid - Title XIX - Hospital - 420087

PART V - APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

	Cost Center Description	Cost to Charge Ratio From Worksheet C			PROGRAM CHARGES						PROGRAM COSTS								
		Part II col. 8	Part I col. 9	Part II col. 9	Outpatient Ambulatory Surgical Center	Outpatient Radiology	Other Outpatient Diagnostic	All Other (1) (see instru.)	PPS services (see instru.)	All Other (see instru.)	Outpatient Ambulatory Surgical Center (cols. 1 × 2)	Outpatient Radiology (cols. 1 × 3)	Other Outpatient Diagnostic (cols. 1 × 4)	All Other (cols. 1 × 5)	PPS services (columns 1.01 × 5.01)	All Other (columns 1.01 × 5.02)	Hospital I/P Part B Charges (see instru.)	Hospital I/P part B Cost (columns 1.02 × 10)	
		1	1.01	1.02	2	3	4	5	5.01	5.02	6	7	8	9	9.01	9.02	10	11	
	OUTPATIENT SERVICE COST CENTERS																		
60.00	Clinic																		60.00
61	Emergency		0.174379	0.174379				4,958,590						810,571					61
62.10	Observation Beds (Non-DistinctPart)		0.778460					41,495						30,217					62.10
63.00	Other Outpatient Service (specify)																		63.00
	OTHER REIMBURSABLE COST CENTERS																		
64	Home Program Dialysis																		64
65	Ambulance		0.577833	0.577833															65
66.00	Durable Medical Equipment-Rented																		66.00
67.00	Durable Medical Equipment-Sold																		67.00
68	Other Reimbursable Cost Center																		68
101	Subtotal (see instructions)							16,328,416						3,043,335					101
102	CRNA Charges (see instructions)																		102
103	Less PBP Clinic Lab. Services-Program Only Charges																		103
104	Net Charges (line 101 ± (lines 102 + 103)							16,328,416						3,043,335					104

PART VI - VACCINE COST APPORTIONMENT

		1	
1	Drugs charged to patients - ratio of cost to charges (from Worksheet C, Part I, column 9, line 56)		1
2	Program vaccine charges (from your records or the PS&R)		2
3	Program costs (line 1 × lines 2) (see instructions for transfer)		3
	(A) Worksheet A line numbers (1) Report non hospital and non subprovider components cost for the period here (see instructions)		

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	COMPUTATION OF INPATIENT OPERATING COST	PROVIDER NO: 420087	PERIOD: FROM 01/01/2010 TO 12/31/2010	WORKSHEET D-1, PART I	
Medicare -Title XVIII - Hospital - 420087					
PART I - ALL PROVIDER COMPONENTS					
	INPATIENT DAYS				
1	Inpatient days (including private room days, and swing-bed days, excluding new born)			65,522	1
2	Inpatient days (including private room days, excluding swing-bed days and new born days)			65,522	2
3	Private room days (excluding swing-bed private room days)				3
4	Semi-private room days (excluding swing-bed private room days)			65,522	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period				5
6	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)				6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period				7
8	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)				8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and new born days)			34,795	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period				10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after Decmeber 31 of the cost reporting period				11
12	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				12
13	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)				13
14	Medically necessary private room days applicable to the Program (excluding swing-bed days)				14
15	Total nursery days				15
16	Title V or XIX nursery days				16
	SWING BED ADJUSTEMENT				
17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period				17
18	Medicare rate for swing-bed SNF services applicable to services after Decmeber 31 of the cost reporting period				18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period				19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period				20
21	Total general inpatient routine service cost (see instructions)			70,640,290	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 × line 17)				22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 × line 18)				23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 × line 18)				24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 × line 20)				25
26	Total swing-bed cost (sum of lines 22 through 25)				26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			70,640,290	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28	General inpatient routine service charges (excluding swing-bed charges)				28
29	Private room charges (excluding swing-bed charges)				29
30	Semi-private room charges (excluding swing-bed charges)				30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)				31
32	Average private room per diem charge (line 29 ÷ line 3)				32
33	Average semi-private room per diem charge (line 30 ÷ line 4)				33
34	Average per diem private room charge differential (line 32 minus line 33)				34
35	Average per diem private private room cost differential (line 34 × line 31)				35
36	Private room cost differential adjustment (line 3 × line 35)				36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			70,640,290	37

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	COMPUTATION OF INPATIENT OPERATING COST	PROVIDER NO: 420087	PERIOD: FROM 01/01/2010 TO 12/31/2010	WORKSHEET D-1, PART I	
Medicare -Title XVIII - Subprovider 1 - 42T087					
PART I - ALL PROVIDER COMPONENTS					
	INPATIENT DAYS				
1	Inpatient days (including private room days, and swing-bed days, excluding new born)			14,038	1
2	Inpatient days (including private room days, excluding swing-bed days and new born days)			14,038	2
3	Private room days (excluding swing-bed private room days)				3
4	Semi-private room days (excluding swing-bed private room days)			14,038	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period				5
6	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)				6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period				7
8	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)				8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and new born days)			8,693	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period				10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after Decmeber 31 of the cost reporting period				11
12	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				12
13	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)				13
14	Medically necessary private room days applicable to the Program (excluding swing-bed days)				14
15	Total nursery days				15
16	Title V or XIX nursery days				16
	SWING BED ADJUSTEMENT				
17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period				17
18	Medicare rate for swing-bed SNF services applicable to services after Decmeber 31 of the cost reporting period				18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period				19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period				20
21	Total general inpatient routine service cost (see instructions)			12,517,253	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 × line 17)				22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 × line 18)				23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 × line 18)				24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 × line 20)				25
26	Total swing-bed cost (sum of lines 22 through 25)				26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			12,517,253	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28	General inpatient routine service charges (excluding swing-bed charges)				28
29	Private room charges (excluding swing-bed charges)				29
30	Semi-private room charges (excluding swing-bed charges)				30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)				31
32	Average private room per diem charge (line 29 ÷ line 3)				32
33	Average semi-private room per diem charge (line 30 ÷ line 4)				33
34	Average per diem private room charge differential (line 32 minus line 33)				34
35	Average per diem private private room cost differential (line 34 × line 31)				35
36	Private room cost differential adjustment (line 3 × line 35)				36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			12,517,253	37

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	COMPUTATION OF INPATIENT OPERATING COST	PROVIDER NO: 420087	PERIOD: FROM 01/01/2010 TO 12/31/2010	WORKSHEET D-1, PART I	
Medicaid - Title XIX - Hospital - 420087					
PART I - ALL PROVIDER COMPONENTS					
	INPATIENT DAYS				
1	Inpatient days (including private room days, and swing-bed days, excluding new born)			65,522	1
2	Inpatient days (including private room days, excluding swing-bed days and new born days)			65,522	2
3	Private room days (excluding swing-bed private room days)				3
4	Semi-private room days (excluding swing-bed private room days)			65,522	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period				5
6	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)				6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period				7
8	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)				8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and new born days)			2,886	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period				10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after Decmeber 31 of the cost reporting period				11
12	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				12
13	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)				13
14	Medically necessary private room days applicable to the Program (excluding swing-bed days)				14
15	Total nursery days			1,354	15
16	Title V or XIX nursery days			326	16
	SWING BED ADJUSTEMENT				
17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period				17
18	Medicare rate for swing-bed SNF services applicable to services after Decmeber 31 of the cost reporting period				18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period				19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period				20
21	Total general inpatient routine service cost (see instructions)			70,640,290	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 × line 17)				22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 × line 18)				23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 × line 18)				24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 × line 20)				25
26	Total swing-bed cost (sum of lines 22 through 25)				26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			70,640,290	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28	General inpatient routine service charges (excluding swing-bed charges)				28
29	Private room charges (excluding swing-bed charges)				29
30	Semi-private room charges (excluding swing-bed charges)				30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)				31
32	Average private room per diem charge (line 29 ÷ line 3)				32
33	Average semi-private room per diem charge (line 30 ÷ line 4)				33
34	Average per diem private room charge differential (line 32 mimus line 33)				34
35	Average per diem private private room cost differential (line 34 × line 31)				35
36	Private room cost differential adjustment (line 3 × line 35)				36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			70,640,290	37

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	COMPUTATION OF INPATIENT OPERATING COST	PROVIDER NO: 420087	PERIOD: FROM 01/01/2010 TO 12/31/2010	WORKSHEET D-1, PART I	
Medicaid - Title XIX - Subprovider 1 - 42T087					
PART I - ALL PROVIDER COMPONENTS					
	INPATIENT DAYS				
1	Inpatient days (including private room days, and swing-bed days, excluding new born)			14,038	1
2	Inpatient days (including private room days, excluding swing-bed days and new born days)			14,038	2
3	Private room days (excluding swing-bed private room days)				3
4	Semi-private room days (excluding swing-bed private room days)			14,038	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period				5
6	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)				6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period				7
8	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)				8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and new born days)				9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period				10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after Decmeber 31 of the cost reporting period				11
12	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				12
13	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)				13
14	Medically necessary private room days applicable to the Program (excluding swing-bed days)				14
15	Total nursery days				15
16	Title V or XIX nursery days				16
	SWING BED ADJUSTEMENT				
17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period				17
18	Medicare rate for swing-bed SNF services applicable to services after Decmeber 31 of the cost reporting period				18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period				19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period				20
21	Total general inpatient routine service cost (see instructions)			12,517,253	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 × line 17)				22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 × line 18)				23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 × line 18)				24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 × line 20)				25
26	Total swing-bed cost (sum of lines 22 through 25)				26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			12,517,253	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28	General inpatient routine service charges (excluding swing-bed charges)				28
29	Private room charges (excluding swing-bed charges)				29
30	Semi-private room charges (excluding swing-bed charges)				30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)				31
32	Average private room per diem charge (line 29 ÷ line 3)				32
33	Average semi-private room per diem charge (line 30 ÷ line 4)				33
34	Average per diem private room charge differential (line 32 minus line 33)				34
35	Average per diem private private room cost differential (line 34 × line 31)				35
36	Private room cost differential adjustment (line 3 × line 35)				36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			12,517,253	37

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COMPUTATION OF INPATIENT OPERATING COST	PROVIDER NO: 420087	PERIOD: FROM 01/01/2010 TO 12/31/2010	WORKSHEET D-1, PART II

Medicare -Title XVIII - Hospital - 420087

	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	1	
38	Adjusted general inpatient routine service cost per diem (see instructions)	1,078.12	38
39	Program general inpatient routine service cost (line 9 × line 38)	37,513,185	39
40	Medically necessary private room cost applicable to the Program (line 14 × line 35)		40
41	Total Program general inpatient routine service cost (line 39 + line 40)	37,513,185	41

		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 × col. 4)	
		1	2	3	4	5	
42	Nursery (title V & XIX only)	1,705,386					42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit	15,644,134	8,753	1787.29	5,126	9,161,649	43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47.00	Other Special Care (specify)						47.00

		1	
48	Program inpatient ancillary service cost (Wkst. D-4, col. 3, line 101)	50,204,242	48
49	Total Program inpatient costs (sum of lines 41 through 48) (see instructions)	96,879,076	49
	PASS THROUGH COST ADJUSTMENTS		
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	7,211,666	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	4,468,504	51
52	Total Program excludable cost (sum of lines 50 and 51)	11,680,170	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist, and medical education costs (line 49 minus line 52)	85,198,906	53
	TARGET AMOUNT AND LIMIT COMPUTATION		
54	Program discharges		54
55	Target amount per discharge		55
56	Target amount (line 54 × line 55)		56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57
58	Bonus payment (see instructions)		58
58.01	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket		58.01
58.02	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket		58.02
58.03	If lines 53/54 is less than the lower of lines 55, 58.01 or 58.02 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 × 58.02), or 1 percent of the target amount (line 56), otherwise enter zero		58.03
58.04	Relief payment (see instructions)		58.04
59	Allowable inpatient cost plus incentive payment (see instructions)		59
	PROGRAM INPATIENT ROUTINE SWING BED COST		
60	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (line 10 × line 17) (title XVIII only)		60
61	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (ilne 11 × line 18) (title XVIII only)		61
62	Total Medicare swing-bed SNF inpatient routine cost (line 60 plus line 61) (title XVIII)		62
63	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reportng period (line 12 × line 19)		63
64	Title V or XIX swing-bed NF inpatient routine csts after December 31 of the cost reporting period (line 13 × line 20)		64
65	Total title V or XIX swing-bed NF inpatient routine costs (line 63 + line 64)		65

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COMPUTATION OF INPATIENT OPERATING COST	PROVIDER NO: 420087	PERIOD: FROM 01/01/2010 TO 12/31/2010	WORKSHEET D-1, PART II

Medicare -Title XVIII - Subprovider 1 - 42T087

	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	1	
38	Adjusted general inpatient routine service cost per diem (see instructions)	891.67	38
39	Program general inpatient routine service cost (line 9 × line 38)	7,751,287	39
40	Medically necessary private room cost applicable to the Program (line 14 × line 35)		40
41	Total Program general inpatient routine service cost (line 39 + line 40)	7,751,287	41

		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 × col. 4)	
		1	2	3	4	5	
42	Nursery (title V & XIX only)	1,705,386					42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit	15,644,134	8,753	1787.29			43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47.00	Other Special Care (specify)						47.00

		1	
48	Program inpatient ancillary service cost (Wkst. D-4, col. 3, line 101)	3,973,355	48
49	Total Program inpatient costs (sum of lines 41 through 48) (see instructions)	11,724,642	49
	PASS THROUGH COST ADJUSTMENTS		
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	1,147,302	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	388,411	51
52	Total Program excludable cost (sum of lines 50 and 51)	1,535,713	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist, and medical education costs (line 49 minus line 52)	10,188,929	53
	TARGET AMOUNT AND LIMIT COMPUTATION		
54	Program discharges		54
55	Target amount per discharge		55
56	Target amount (line 54 × line 55)		56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57
58	Bonus payment (see instructions)		58
58.01	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket		58.01
58.02	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket		58.02
58.03	If lines 53/54 is less than the lower of lines 55, 58.01 or 58.02 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 × 58.02), or 1 percent of the target amount (line 56), otherwise enter zero		58.03
58.04	Relief payment (see instructions)		58.04
59	Allowable inpatient cost plus incentive payment (see instructions)		59
	PROGRAM INPATIENT ROUTINE SWING BED COST		
60	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (line 10 × line 17) (title XVIII only)		60
61	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (line 11 × line 18) (title XVIII only)		61
62	Total Medicare swing-bed SNF inpatient routine cost (line 60 plus line 61) (title XVIII)		62
63	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 × line 19)		63
64	Title V or XIX swing-bed NF inpatient routine cst after December 31 of the cost reporting period (line 13 × line 20)		64
65	Total title V or XIX swing-bed NF inpatient routine costs (line 63 + line 64)		65

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COMPUTATION OF INPATIENT OPERATING COST	PROVIDER NO: 420087	PERIOD: FROM 01/01/2010 TO 12/31/2010	WORKSHEET D-1, PART II

Medicaid - Title XIX - Hospital - 420087

	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	1	
38	Adjusted general inpatient routine service cost per diem (see instructions)	1,078.12	38
39	Program general inpatient routine service cost (line 9 × line 38)	3,111,454	39
40	Medically necessary private room cost applicable to the Program (line 14 × line 35)		40
41	Total Program general inpatient routine service cost (line 39 + line 40)	3,111,454	41

		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 × col. 4)	
		1	2	3	4	5	
42	Nursery (title V & XIX only)	1,705,386	1,354	1259.52	326	410,604	42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit	15,644,134	8,753	1787.29	361	645,212	43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47.00	Other Special Care (specify)						47.00

		1	
48	Program inpatient ancillary service cost (Wkst. D-4, col. 3, line 101)	3,984,803	48
49	Total Program inpatient costs (sum of lines 41 through 48) (see instructions)	8,152,073	49
	PASS THROUGH COST ADJUSTMENTS		
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)		50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51
52	Total Program excludable cost (sum of lines 50 and 51)		52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist, and medical education costs (line 49 minus line 52)		53
	TARGET AMOUNT AND LIMIT COMPUTATION		
54	Program discharges		54
55	Target amount per discharge		55
56	Target amount (line 54 × line 55)		56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57
58	Bonus payment (see instructions)		58
58.01	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket		58.01
58.02	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket		58.02
58.03	If lines 53/54 is less than the lower of lines 55, 58.01 or 58.02 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 × 58.02), or 1 percent of the target amount (line 56), otherwise enter zero		58.03
58.04	Relief payment (see instructions)		58.04
59	Allowable inpatient cost plus incentive payment (see instructions)		59
	PROGRAM INPATIENT ROUTINE SWING BED COST		
60	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (line 10 × line 17) (title XVIII only)		60
61	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (ilne 11 × line 18) (title XVIII only)		61
62	Total Medicare swing-bed SNF inpatient routine cost (line 60 plus line 61) (title XVIII)		62
63	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 × line 19)		63
64	Title V or XIX swing-bed NF inpatient routine csts after December 31 of the cost reporting period (line 13 × line 20)		64
65	Total title V or XIX swing-bed NF inpatient routine costs (line 63 + line 64)		65

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COMPUTATION OF INPATIENT OPERATING COST	PROVIDER NO: 420087	PERIOD: FROM 01/01/2010 TO 12/31/2010	WORKSHEET D-1, PART II

Medicaid - Title XIX - Subprovider 1 - 42T087

	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	1	
38	Adjusted general inpatient routine service cost per diem (see instructions)	891.67	38
39	Program general inpatient routine service cost (line 9 × line 38)		39
40	Medically necessary private room cost applicable to the Program (line 14 × line 35)		40
41	Total Program general inpatient routine service cost (line 39 + line 40)		41

		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 × col. 4)	
		1	2	3	4	5	
42	Nursery (title V & XIX only)	1,705,386					42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit	15,644,134	8,753	1787.29			43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47.00	Other Special Care (specify)						47.00

		1	
48	Program inpatient ancillary service cost (Wkst. D-4, col. 3, line 101)		48
49	Total Program inpatient costs (sum of lines 41 through 48) (see instructions)		49
	PASS THROUGH COST ADJUSTMENTS		
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)		50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51
52	Total Program excludable cost (sum of lines 50 and 51)		52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist, and medical education costs (line 49 minus line 52)		53
	TARGET AMOUNT AND LIMIT COMPUTATION		
54	Program discharges		54
55	Target amount per discharge		55
56	Target amount (line 54 × line 55)		56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57
58	Bonus payment (see instructions)		58
58.01	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket		58.01
58.02	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket		58.02
58.03	If lines 53/54 is less than the lower of lines 55, 58.01 or 58.02 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 × 58.02), or 1 percent of the target amount (line 56), otherwise enter zero		58.03
58.04	Relief payment (see instructions)		58.04
59	Allowable inpatient cost plus incentive payment (see instructions)		59
	PROGRAM INPATIENT ROUTINE SWING BED COST		
60	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (line 10 × line 17) (title XVIII only)		60
61	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (ilne 11 × line 18) (title XVIII only)		61
62	Total Medicare swing-bed SNF inpatient routine cost (lne 60 plus line 61) (title XVIII)		62
63	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 × line 19)		63
64	Title V or XIX swing-bed NF inpatient routine csts after December 31 of the cost reporting period (line 13 × line 20)		64
65	Total title V or XIX swing-bed NF inpatient routine costs (line 63 + line 64)		65

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COMPUTATION OF INPATIENT OPERATING COST	PROVIDER NO: 420087	PERIOD: FROM 01/01/2010 TO 12/31/2010	WORKSHEET D-1, PARTS III & IV

Medicare -Title XVIII - Hospital - 420087

PART III - SKILLED NURSING FACILITY, NURSING FACILITY AND ICF/MR ONLY

66	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)		66
67	Adjusted general inpatient routine service cost per diem (line 66 ÷ line 2)		67
68	Program routine service cost (line 9 × line 67)		68
69	medically necessary private room cost applicable to Program (line 14 × line 35)		69
70	Total Program general inpatient routine service costs (line 68 + line 69)		70
71	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, sum of Parts II and III, column 27)		71
72	Per diem capital-related costs (line 71 ÷ line 2)		72
73	Program capital-related costs (line 9 × line 72)		73
74	Inpatient routine service cost (line 70 minus line 73)		74
75	Aggregate charges to beneficiaries for excess costs (from provider records)		75
76	Total Program routine services costs for comparison to the cost limitation (line 74 minus line 75)		76
77	Inpatient routine service cost per diem limitation		77
78	Inpatient routine service cost limitation (line 9 × line 77)		78
79	Reasonable inpatient routine service costs (see instructions)		79
80	Program inpatient ancillary services (see instructions)		80
81	Utilization review - physician compensation		81
82	Total Program inpatient operating costs (sum of lines 79 through 81)		82

PART IV - PART IV - COMPUTATION OF OBSERVATION BED COST

83	Total observation bed days (see instructions)	2,600	83
84	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,078.12	84
85	Observation bed cost (line 83 × line 84) (see instructions)	2,803,112	85

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

		Cost	Routine Cost (from line 27)	col. 1 ÷ col. 2	Total Observation Bed Cost (from line 85)	Observation Bed Pass Through Cost (col. 3 × col. 4) (see instructions)	
		1	2	3	4	5	
86	Old capital-related cost		70,640,290		2,803,112		86
87	New capital-related cost	11,001,916	70,640,290	0.155746	2,803,112	436,573	87
88	Non Physician Anesthetist		70,640,290		2,803,112		88
89	Medical Education	161,777	70,640,290	0.002290	2,803,112		89

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COMPUTATION OF INPATIENT OPERATING COST	PROVIDER NO: 420087	PERIOD: FROM 01/01/2010 TO 12/31/2010	WORKSHEET D-1, PARTS III & IV

Medicare -Title XVIII - Subprovider 1 - 42T087

PART III - SKILLED NURSING FACILITY, NURSING FACILITY AND ICF/MR ONLY

66	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)		66
67	Adjusted general inpatient routine service cost per diem (line 66 ÷ line 2)		67
68	Program routine service cost (line 9 × line 67)		68
69	medically necessary private room cost applicable to Program (line 14 × line 35)		69
70	Total Program general inpatient routine service costs (line 68 + line 69)		70
71	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, sum of Parts II and III, column 27)		71
72	Per diem capital-related costs (line 71 ÷ line 2)		72
73	Program capital-related costs (line 9 × line 72)		73
74	Inpatient routine service cost (line 70 minus line 73)		74
75	Aggregate charges to beneficiaries for excess costs (from provider records)		75
76	Total Program routine services costs for comparison to the cost limitation (line 74 minus line 75)		76
77	Inpatient routine service cost per diem limitation		77
78	Inpatient routine service cost limitation (line 9 × line 77)		78
79	Reasonable inpatient routine service costs (see instructions)		79
80	Program inpatient ancillary services (see instructions)		80
81	Utilization review - physician compensation		81
82	Total Program inpatient operating costs (sum of lines 79 through 81)		82

PART IV - PART IV - COMPUTATION OF OBSERVATION BED COST

83	Total observation bed days (see instructions)		83
84	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	891.67	84
85	Observation bed cost (line 83 × line 84) (see instructions)		85

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

		Cost	Routine Cost (from line 27)	col. 1 ÷ col. 2	Total Observation Bed Cost (from line 85)	Observation Bed Pass Through Cost (col. 3 × col. 4) (see instructions)	
		1	2	3	4	5	
86	Old capital-related cost		12,517,253				86
87	New capital-related cost		12,517,253				87
88	Non Physician Anesthetist		12,517,253				88
89	Medical Education		12,517,253				89

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COMPUTATION OF INPATIENT OPERATING COST	PROVIDER NO: 420087	PERIOD: FROM 01/01/2010 TO 12/31/2010	WORKSHEET D-1, PARTS III & IV

Medicaid - Title XIX - Hospital - 420087

	PART III - SKILLED NURSING FACILITY, NURSING FACILITY AND ICF/MR ONLY		
66	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)		66
67	Adjusted general inpatient routine service cost per diem (line 66 ÷ line 2)		67
68	Program routine service cost (line 9 × line 67)		68
69	medically necessary private room cost applicable to Program (line 14 × line 35)		69
70	Total Program general inpatient routine service costs (line 68 + line 69)		70
71	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, sum of Parts II and III, column 27)		71
72	Per diem capital-related costs (line 71 ÷ line 2)		72
73	Program capital-related costs (line 9 × line 72)		73
74	Inpatient routine service cost (line 70 minus line 73)		74
75	Aggregate charges to beneficiaries for excess costs (from provider records)		75
76	Total Program routine services costs for comparison to the cost limitation (line 74 minus line 75)		76
77	Inpatient routine service cost per diem limitation		77
78	Inpatient routine service cost limitation (line 9 × line 77)		78
79	Reasonable inpatient routine service costs (see instructions)		79
80	Program inpatient ancillary services (see instructions)		80
81	Utilization review - physician compensation		81
82	Total Program inpatient operating costs (sum of lines 79 through 81)		82
	PART IV - PART IV - COMPUTATION OF OBSERVATION BED COST		
83	Total observation bed days (see instructions)	2,600	83
84	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,078.12	84
85	Observation bed cost (line 83 × line 84) (see instructions)	2,803,112	85

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

		Cost	Routine Cost (from line 27)	col. 1 ÷ col. 2	Total Observation Bed Cost (from line 85)	Observation Bed Pass Through Cost (col. 3 × col. 4) (see instructions)	
		1	2	3	4	5	
86	Old capital-related cost		70,640,290		2,803,112		86
87	New capital-related cost		70,640,290		2,803,112		87
88	Non Physician Anesthetist		70,640,290		2,803,112		88
89	Medical Education		70,640,290		2,803,112		89

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COMPUTATION OF INPATIENT OPERATING COST	PROVIDER NO: 420087	PERIOD: FROM 01/01/2010 TO 12/31/2010	WORKSHEET D-1, PARTS III & IV

Medicaid - Title XIX - Subprovider 1 - 42T087

PART III - SKILLED NURSING FACILITY, NURSING FACILITY AND ICF/MR ONLY

66	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)		66
67	Adjusted general inpatient routine service cost per diem (line 66 ÷ line 2)		67
68	Program routine service cost (line 9 × line 67)		68
69	medically necessary private room cost applicable to Program (line 14 × line 35)		69
70	Total Program general inpatient routine service costs (line 68 + line 69)		70
71	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, sum of Parts II and III, column 27)		71
72	Per diem capital-related costs (line 71 ÷ line 2)		72
73	Program capital-related costs (line 9 × line 72)		73
74	Inpatient routine service cost (line 70 minus line 73)		74
75	Aggregate charges to beneficiaries for excess costs (from provider records)		75
76	Total Program routine services costs for comparison to the cost limitation (line 74 minus line 75)		76
77	Inpatient routine service cost per diem limitation		77
78	Inpatient routine service cost limitation (line 9 × line 77)		78
79	Reasonable inpatient routine service costs (see instructions)		79
80	Program inpatient ancillary services (see instructions)		80
81	Utilization review - physician compensation		81
82	Total Program inpatient operating costs (sum of lines 79 through 81)		82

PART IV - PART IV - COMPUTATION OF OBSERVATION BED COST

83	Total observation bed days (see instructions)		83
84	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	891.67	84
85	Observation bed cost (line 83 × line 84) (see instructions)		85

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

		Cost	Routine Cost (from line 27)	col. 1 ÷ col. 2	Total Observation Bed Cost (from line 85)	Observation Bed Pass Through Cost (col. 3 × col. 4) (see instructions)	
		1	2	3	4	5	
86	Old capital-related cost		12,517,253				86
87	New capital-related cost		12,517,253				87
88	Non Physician Anesthetist		12,517,253				88
89	Medical Education		12,517,253				89

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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	PROVIDER NO: 420087	PERIOD: FROM 01/01/2010 TO 12/31/2010	WORKSHEET D-4

Medicare -Title XVIII - Hospital - 420087

	COST CENTER DESCRIPTION	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 × col. 2)	
		1	2	3	
(A)	INPATIENT ROUTINE SERVICE COST CENTERS				
25	Adults and Pediatrics (General Routine Care)		54,208,968		25
26	Intensive Care Units		17,357,850		26
27	Coronary Care Unit				27
28	Burn Intensive Care Unit				28
29	Surgical Intensive Care Unit				29
30.00	Other Special Care (specify)				30.00
31.00	Subprovider				31.00
	ANCILLARY SERVICE COST CENTERS				
37.05	Operating Room	0.244761	42,792,903	10,474,034	37.05
38	Recovery Room	0.241444	3,053,608	737,275	38
39.05	Delivery Room & Labor Room	0.613985	27,358	16,797	39.05
40.00	Anesthesiology				40.00
41.05	Radiology-Diagnostic	0.135138	18,309,521	2,474,312	41.05
42.05	Radiology-Therapeutic	0.225405	1,400,465	315,672	42.05
43	Radioisotope				43
44.05	Laboratory	0.125431	42,082,785	5,278,486	44.05
44.45	Vascular Lab	0.221401	2,384,885	528,016	44.45
45	PBP Clinic Laboratory Services-Program Only				45
46.00	Whole Blood & Packed Red Blood Cells				46.00
47	Blood Storing, Processing, & Transfusing	0.236766	9,123,040	2,160,026	47
48	Intravenous Therapy				48
49.05	Respiratory Therapy	0.336995	6,414,514	2,161,659	49.05
50.05	Physical Therapy	0.265741	4,755,498	1,263,731	50.05
51	Occupational Therapy				51
52	Speech Pathology				52
53.05	Electrocardiology	0.106761	5,641,051	602,244	53.05
53.40	Cardiac Catheterization Laboratory	0.120571	14,899,552	1,796,454	53.40
54	Electroencephalography				54
55	Medical Supplies Charged to Patients				55
55.30	Implantable Devices Charged to Patients	0.392521	24,834,448	9,748,042	55.30
56	Drugs Charged to Patients	0.288760	33,640,247	9,713,958	56
57	Renal Dialysis				57
58	ASC (Non-Distinct Part)				58
59.30	Other Ancillary Cost Centers	1.693779	612,474	1,007,322	59.30
	OUTPATIENT SERVICE COST CENTERS				
60.00	Clinic				60.00
61	Emergency	0.174379	11,046,134	1,926,214	61
62.10	Observation Beds (Non-DistinctPart)	0.778460			62.10
63.00	Other Outpatient Service (specify)				63.00
	OTHER REIMBURSABLE COST CENTERS				
64	Home Program Dialysis				64
65	Ambulance				65
66.00	Durable Medical Equipment-Rented				66.00
67.00	Durable Medical Equipment-Sold				67.00
68	Other Reimbursable (specify)				68
101	Total (sum of lines 37-64 and 66-68)		221,018,483	50,204,242	101
102	Less PBP Clinic Laboratory Services-Program only charges (line 45)				102
103	Net Charges (line 101 minus line 102)		221,018,483		103

(A) Worksheet A line numbers

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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	PROVIDER NO: 420087	PERIOD: FROM 01/01/2010 TO 12/31/2010	WORKSHEET D-4

Medicare -Title XVIII - Subprovider 1 - 42T087

	COST CENTER DESCRIPTION	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 × col. 2)	
		1	2	3	
(A)	**INPATIENT ROUTINE SERVICE COST CENTERS**				
25	Adults and Pediatrics (General Routine Care)				25
26	Intensive Care Units				26
27	Coronary Care Unit				27
28	Burn Intensive Care Unit				28
29	Surgical Intensive Care Unit				29
30.00	Other Special Care (specify)				30.00
31.00	Subprovider		11,934,392		31.00
	ANCILLARY SERVICE COST CENTERS				
37.05	Operating Room	0.244761	243,091	59,499	37.05
38	Recovery Room	0.241444	18,278	4,413	38
39.05	Delivery Room & Labor Room	0.613985			39.05
40.00	Anesthesiology				40.00
41.05	Radiology-Diagnostic	0.135138	541,150	73,130	41.05
42.05	Radiology-Therapeutic	0.225405	17,478	3,940	42.05
43	Radioisotope				43
44.05	Laboratory	0.125431	2,381,163	298,672	44.05
44.45	Vascular Lab	0.221401	746,822	165,347	44.45
45	PBP Clinic Laboratory Services-Program Only				45
46.00	Whole Blood & Packed Red Blood Cells				46.00
47	Blood Storing, Processing, & Transfusing	0.236766	70,117	16,601	47
48	Intravenous Therapy				48
49.05	Respiratory Therapy	0.336995	272,880	91,959	49.05
50.05	Physical Therapy	0.265741	9,697,037	2,576,900	50.05
51	Occupational Therapy				51
52	Speech Pathology				52
53.05	Electrocardiology	0.106761	82,729	8,832	53.05
53.40	Cardiac Catheterization Laboratory	0.120571			53.40
54	Electroencephalography				54
55	Medical Supplies Charged to Patients				55
55.30	Implantable Devices Charged to Patients	0.392521	52,950	20,784	55.30
56	Drugs Charged to Patients	0.288760	2,127,859	614,441	56
57	Renal Dialysis				57
58	ASC (Non-Distinct Part)				58
59.30	Other Ancillary Cost Centers	1.693779	20,237	38,837	59.30
	OUTPATIENT SERVICE COST CENTERS				
60.00	Clinic				60.00
61	Emergency	0.174379			61
62.10	Observation Beds (Non-DistinctPart)	0.778460			62.10
63.00	Other Outpatient Service (specify)				63.00
	OTHER REIMBURSABLE COST CENTERS				
64	Home Program Dialysis				64
65	Ambulance				65
66.00	Durable Medical Equipment-Rented				66.00
67.00	Durable Medical Equipment-Sold				67.00
68	Other Reimbursable (specify)				68
101	Total (sum of lines 37-64 and 66-68)		16,271,791	3,973,355	101
102	Less PBP Clinic Laboratory Services-Program only charges (line 45)				102
103	Net Charges (line 101 minus line 102)		16,271,791		103

(A) Worksheet A line numbers

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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	PROVIDER NO: 420087	PERIOD: FROM 01/01/2010 TO 12/31/2010	WORKSHEET D-4

Medicaid - Title XIX - Hospital - 420087

	COST CENTER DESCRIPTION	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 × col. 2)	
		1	2	3	
(A)	INPATIENT ROUTINE SERVICE COST CENTERS				
25	Adults and Pediatrics (General Routine Care)		4,181,008		25
26	Intensive Care Units		1,216,580		26
27	Coronary Care Unit				27
28	Burn Intensive Care Unit				28
29	Surgical Intensive Care Unit				29
30.00	Other Special Care (specify)				30.00
31.00	Subprovider				31.00
	ANCILLARY SERVICE COST CENTERS				
37.05	Operating Room	0.244761	1,963,180	480,510	37.05
38	Recovery Room	0.241444	179,889	43,433	38
39.05	Delivery Room & Labor Room	0.613985	1,585,337	973,373	39.05
40.00	Anesthesiology				40.00
41.05	Radiology-Diagnostic	0.135138	1,011,721	136,722	41.05
42.05	Radiology-Therapeutic	0.225405	209,459	47,213	42.05
43	Radioisotope				43
44.05	Laboratory	0.125431	3,023,881	379,288	44.05
44.45	Vascular Lab	0.221401	69,892	15,474	44.45
45	PBP Clinic Laboratory Services-Program Only				45
46.00	Whole Blood & Packed Red Blood Cells				46.00
47	Blood Storing, Processing, & Transfusing	0.236766	838,892	198,621	47
48	Intravenous Therapy				48
49.05	Respiratory Therapy	0.336995	418,270	140,989	49.05
50.05	Physical Therapy	0.265741	208,786	55,483	50.05
51	Occupational Therapy				51
52	Speech Pathology				52
53.05	Electrocardiology	0.106761	250,988	26,796	53.05
53.40	Cardiac Catheterization Laboratory	0.120571	401,199	48,373	53.40
54	Electroencephalography				54
55	Medical Supplies Charged to Patients				55
55.30	Implantable Devices Charged to Patients	0.392521	764,058	299,909	55.30
56	Drugs Charged to Patients	0.288760	3,220,737	930,020	56
57	Renal Dialysis				57
58	ASC (Non-Distinct Part)				58
59.30	Other Ancillary Cost Centers	1.693779	34,551	66,307	59.30
	OUTPATIENT SERVICE COST CENTERS				
60.00	Clinic				60.00
61	Emergency	0.174379	815,993	142,292	61
62.10	Observation Beds (Non-DistinctPart)	0.778460			62.10
63.00	Other Outpatient Service (specify)				63.00
	OTHER REIMBURSABLE COST CENTERS				
64	Home Program Dialysis				64
65	Ambulance				65
66.00	Durable Medical Equipment-Rented				66.00
67.00	Durable Medical Equipment-Sold				67.00
68	Other Reimbursable (specify)				68
101	Total (sum of lines 37-64 and 66-68)		14,996,933	3,984,803	101
102	Less PBP Clinic Laboratory Services-Program only charges (line 45)				102
103	Net Charges (line 101 minus line 102)		14,996,933		103

(A) Worksheet A line numbers

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	CALCULATION OF REIMBURSEMENT SETTLEMENT	PROVIDER NO: 420087	PERIOD: FROM: 01/01/2010 TO: 12/31/2010	WORKSHEET E, PART A	
Medicare -Title XVIII - Hospital - 420087					
	PART A - INPATIENT HOSPITAL SERVICES UNDER PPS		1	1.01	
	DRG Amount				
1	Other than Outlier Payments occurring prior to October 1		47,501,944		1
1.01	Other than Outlier Payments occurring on or after October 1 and before January 1		15,833,981		1.01
1.02	Other than Outlier Payments occurring on or after January 1				1.02
	Managed Care Patients				
1.03	Payments prior to March 1st or October 1st				1.03
1.04	Payments on or after October 1 and prior to January 1				1.04
1.05	Payments on or after January 1st but before April 1st/October 1st				1.05
1.06	Additional amount received or to be received (see instructions)				1.06
1.07	Payments for discharges on or after April 1, 2001 through September 30, 2001				1.07
1.08	Simulated payments from the PS&R on or afetr April 1, 2001 through September 30, 2001				1.08
2	Outlier payments for discharges occuring prior to October 1, 1997 (see instructions)				2
2.01	Outlier payments for discharges occurring on or after October 1, 1997 (see instructions)		2,942,620		2.01
	Indirect Medical Education Adjustment				
3	Bed days available divided by number of days in the cost reporting period (see instructions)		379.67		3
3.01	Number of Interns & Residents from Worksheet S-3, Part I				3.01
3.02	Indirect medical education percentage (see instructions)				3.02
3.03	Indirect medical education adjustment (sum of lines 1, 1.01, 1.02, and 2 times line 3.02)				3.03
3.04	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996				3.04
3.05	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with section 1886(d)(5)(B)(viii)				3.05
3.06	Adjusted FTE count for allopathic and osteopathic programs for affiliated programs in accordance with section 1886(d)(5)(B)(viii)				3.06
3.07	Sum of lines 3.04 through 3.06				3.07
3.08	FTE count for allopathic and osteopathic programs in the current year from your records				3.08
3.09	For cost reporting periods beginning before October 1, enter the percentage of discharges occurring prior to October 1				3.09
3.10	For cost reporting periods beginning before October 1, enter the percentage of discharges occurring on or after October 1				3.10
3.11	FTE count for the period identified in line 3.09				3.11
3.12	FTE count for the period identified in line 3.10				3.12
3.13	FTE count for residents in dental and podiatric programs				3.13
3.14	Current year allowable FTE (see instructions)				3.14
3.15	Total allowable FTE count for the prior year, if none but prior year teaching was in effect enter 1 here				3.15
3.16	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otehrwise enter zero. If there was no FTE count in this period but prior year teaching was in effect enter 1 here				3.16
3.17	Sum of lines 3.14 through 3.16 divided by the number of those lines in excess of zero (see instructions)				3.17
3.18	Current year residents to bed ratio (line 3.17 divided by line 3)				3.18
3.19	Prior year resident to bed ratio (see instructions)				3.19
3.20	For cost reporting periods beginning on or after October 1, 1997, enter the lesser of lines 3.18 or 3.19				3.20
3.21	IME payments for discharges occurring prior to October 1 (see instructions)				3.21
3.22	IME payments for discharges occurring on or after October 1 but before January 1 (see instructions)				3.22
3.23	IME payments for discharges occurring on or after January 1 (see instructions)				3.23
3.24	Sum of lines 3.21 through 3.23				3.24
	Disproportionate Share Adjustment				
4	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		0.091300		4
4.01	Percentage of Medicaid patient days to total days reported on Worksheet S-3, Part I		0.096100		4.01
4.02	Sum of lines 4 and 4.01		0.187400		4.02
4.03	Allowable disproportionate share percentage (see instructions)		0.049300		4.03
4.04	Disproportionate share adjustment (sum of lines 1, 1.01, 1.02, and 2 times line 4.03)		3,122,461		4.04
PART A - INPATIENT HOSPITAL SERVICES UNDER PPS					
	Additional payment for high percentage of ESRD beneficiary discharges				
5	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for DRGs 302, 316, 317 or MS-DRG 652, 682 - 685. (see instructions)				5
5.01	Total ESRD Medicare discharges excluding DRGs 302, 316, and 317, or MS-DRGs 652 and 682 - 685 (see instructions)				5.01
5.02	Divide line 5.01 by line 5 (if less than 10%, you do not qualify for adjustment)				5.02

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	CALCULATION OF REIMBURSEMENT SETTLEMENT	PROVIDER NO: 420087	PERIOD: FROM: 01/01/2010 TO: 12/31/2010	WORKSHEET E, PART A	
Medicare -Title XVIII - Hospital - 420087					
5.03	Total medicare ESRD inpatient days excluding DRGs 302, 316, 317, or MS-DRGs 652, 682 - 685.(see instructions)				5.03
5.04	Ratio of average length of stay to one week (line 5.03 divided by line 5.01 divided by 7)				5.04
5.05	Average weekly cost for dialysis treatments (see instructions)				5.05
5.06	Total additional payment (line 5.04 times line 5.05 times line 5.01)				5.06
6	Subtotal (see instructions)		69,401,006		6
7	Hospital specific payments (to be completed by SCH and MDC, small rural hospitals only)				7
7.01	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.See instructions FY beg. 10/1/00)				7.01
8	Total payment for inpatient operating costs (for SCH and MDH, small rural hospitals, higher of lines 6 or 7, all other providers, enter amount from line 6 on this line.)		69,401,006		8
9	Payment for inpatient program capital (from Worksheet L, parts I, II, or III, as applicable)		5,606,987		9
10	Exception payment for inpatient program capital (Worksheet L, Part IV, line 13)				10
11	Direct graduate medical eduation payment (from Worksheet E-3, Part IV)				11
11.01	Nursing and Allied Health Managed Care				11.01
11.02	Special add-on payments for new technologies				11.02
12	Net organ acquisition cost				12
13	Cost of teaching physicians				13
14	Routine service other pass through costs		109,216		14
15	Ancillary service other pass through costs		10,280		15
16	Total (sum of amounts on lines 8 through 15)		75,127,489		16
17	Primary payer payments		34,459		17
18	Total amount payable for program beneficiaries (line 16 minus line 17)		75,093,030		18
19	Deductibles billed to program beneficiaries		5,794,440		19
20	Coinsurance billed program beneficiaries		336,523		20
21	Reimbursable bad debts (see instructions)		631,201		21
21.01	Adjusted reimbursable bed debts (see instructions)		441,841		21.01
21.02	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		76,893		21.02
22	Subtotal (line 18 plus line 21.01 minus lines 19 and 20)		69,403,908		22
23	Recovery of excess depreciation resulting from provider termination or a decrease in program utilization				23
24	Other adjustments (see instructions) (specify)				24
24.99	Other adjustments - Outlier reconsiliation				24.99
25	Amounts applicable to prior cost reporting periods resulting from disposition of depreciable assets)				25
26	Amount due provider (line 22 plus or minus lines 24 and 25 minus line 23)		69,403,908		26
27	Sequestration adjustment (see instructions)				27
28	Interim payments		68,725,526		28
28.01	Tentative settlement (for fiscal intermediary use only)				28.01
29	Balance due provider (Program) (line 26 minus the sum of lines 27, 28, and 28.01)		678,382		29
30	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2				30
TO BE COMPLETED BY INTERMEDIARY					
50	Operating outlier amount from Worksheet E, Part A line 2.01				50
51	Capital outlier amount from Worksheet L, Part I line 3.01				51
52	Operating outlier reconciliation adjustment amount (see instructions)				52
53	Capital outlier reconciliation adjustment amount (see instructions)				53
54	The rate used to calculate the Time Value of Money (see instructions)				54
55	Operating Time Value of Money (see instructions)				55
56	Capital Time Value of Money (see instructions)				56

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	CALCULATION OF REIMBURSEMENT SETTLEMENT	PROVIDER NO: 420087	PERIOD: FROM 01/01/2010 TO 12/31/2010	WORKSHEET E PART B	
Medicare -Title XVIII - Hospital - 420087					
PART B - MEDICAL AND OTHER HEALTH SERVICES					
1	Medical and other services (see instructions)				1
1.01	Medical and other services rendered on or after August 1, 2000 from Worksheet D, Part V, column 9.01, line 104			39,420,775	1.01
1.02	PPS payments received including outliers			37,966,511	1.02
1.03	Enter the 1996 hospital specific payment to cost ratio				1.03
1.04	Line 1.01 times line 1.03				1.04
1.05	Line 1.02 divided by line 1.04				1.05
1.06	Transitional corridor payment (see instructions)				1.06
1.07	Enter the amount from Worksheet D, Part IV, column 9, line 101			12,580	1.07
2	Interns and residents				2
3	Organ acquisitions				3
4	Cost of teaching physicians				4
5	Total cost (see instructions)				5
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable charges				
6	Ancillary service charges				6
7	Interns and residents service charges				7
8	Organ acquisition charges (from Worksheet D-6, Part III, line 61, col. 4)				8
9	Charges of professional services of teaching physicians				9
10	Total reasonable charges (sum of lines 6 through 9)				10
	Customary charges				
11	Aggregate amount actually collected from patients liable for payment for services on a charge basis				11
12	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)				12
13	Ratio of line 11 to line 12 (not to exceed 1.000000)				13
14	Total customary charges (see instructions)				14
15	Excess of customary chages over reasonable cost (complete only if line 14 exceeds line 5) (see instructions)				15
16	Excess of reasonable cost over customary charges (complete only if line 5 exceeds line 14) (see instructions)				16
17	Lesser of cost or charges (line 5 or line 14) (see instructions)				17
17.01	Total prospective payment (sum of lines 1.01, 1 06. 1.07)			37,979,091	17.01
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18	Deductibles and coinsurance (see instructions)				18
18.01	Coinsurance relating to amount on line 17.01			7,866,665	18.01
19	Subtotal (line 17 minus line 18)			30,112,426	19
20	Sum of amounts from Worksheet E, Parts C, D, and E (see instructions)				20
21	Direct graduate medical education payments (from Worksheet E-3, Part IV)				21
22	ESRD direct medical education costs (from Worksheet E-3, Part IV)				22
23	Subtotal (sum of lines 19 through 22)			30,112,426	23
24	Primary payer payments			9,794	24
25	Subtotal (line 23 minus line 24)			30,102,632	25
	Reimbursable bad debts (exclude bad debts for professional services)				
26	Composite rate ESRD (from Worksheet I-5, line 9)				26
27	Bad debts (see instructions)			944,312	27
27.01	Adjusted reimbursable bad debts (see instructions)			661,018	27.01
27.02	Reimbursable bad debts for dual eligible beneficiaries			519,782	27.02
28	Subtotal (sum of lines 25, 26, and 27 or 27.01) (line 27.01 hospital and subprovider only)			30,763,650	28
29	Recovery of excess depreciation resulting from provider termination or a decrease in program utilization				29
30	Other adjustments (specify) (see instructions)				30
31	Amounts applicable to prior cost reporting periods resulting from disposition of depreciable assets				31
32	Subtotal (line 28 plus or minus lines 30 and 31 minus line 29)			30,763,650	32
33	Sequestration adjustment (see instructions)				33
34	Interim payments			31,256,906	34
34.01	Tentative settlement (for fiscal intermediary use only)				34.01
35	Balance due provider/program (line 32 minus the sum of ilnes 33, 34, and 34.01)			-493,256	35
36	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2				36
TO BE COMPLETED BY CONTRACTOR					
50	Original outlier amount (see instructions)				50
51	Outlier reconciliation amount (see instructions)				51

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	CALCULATION OF REIMBURSEMENT SETTLEMENT	PROVIDER NO: 420087	PERIOD: FROM 01/01/2010 TO 12/31/2010	WORKSHEET E PART B	
Medicare -Title XVIII - Hospital - 420087					
52	The rate used to calculate the Time Value of Money				52
53	Time Value of Money (see instructions)				53
54	Total (sum of lines 51 and 53)				54

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	CALCULATION OF REIMBURSEMENT SETTLEMENT	PROVIDER NO: 420087	PERIOD: FROM 01/01/2010 TO 12/31/2010	WORKSHEET E PART B	
Medicare -Title XVIII - Subprovider 1 - 42T087					
PART B - MEDICAL AND OTHER HEALTH SERVICES					
1	Medical and other services (see instructions)				1
1.01	Medical and other services rendered on or after August 1, 2000 from Worksheet D, Part V, column 9.01, line 104			653	1.01
1.02	PPS payments received including outliers			418	1.02
1.03	Enter the 1996 hospital specific payment to cost ratio				1.03
1.04	Line 1.01 times line 1.03				1.04
1.05	Line 1.02 divided by line 1.04				1.05
1.06	Transitional corridor payment (see instructions)				1.06
1.07	Enter the amount from Worksheet D, Part IV, column 9, line 101				1.07
2	Interns and residents				2
3	Organ acquisitions				3
4	Cost of teaching physicians				4
5	Total cost (see instructions)				5
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable charges				
6	Ancillary service charges				6
7	Interns and residents service charges				7
8	Organ acquisition charges (from Worksheet D-6, Part III, line 61, col. 4)				8
9	Charges of professional services of teaching physicians				9
10	Total reasonable charges (sum of lines 6 through 9)				10
	Customary charges				
11	Aggregate amount actually collected from patients liable for payment for services on a charge basis				11
12	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)				12
13	Ratio of line 11 to line 12 (not to exceed 1.000000)				13
14	Total customary charges (see instructions)				14
15	Excess of customary chages over reasonable cost (complete only if line 14 exceeds line 5) (see instructions)				15
16	Excess of reasonable cost over customary charges (complete only if line 5 exceeds line 14) (see instructions)				16
17	Lesser of cost or charges (line 5 or line 14) (see instructions)				17
17.01	Total prospective payment (sum of lines 1.01, 1.06, 1.07)			418	17.01
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18	Deductibles and coinsurance (see instructions)				18
18.01	Coinsurance relating to amount on line 17.01			146	18.01
19	Subtotal (line 17 minus line 18)			272	19
20	Sum of amounts from Worksheet E, Parts C, D, and E (see instructions)				20
21	Direct graduate medical education payments (from Worksheet E-3, Part IV)				21
22	ESRD direct medical education costs (from Worksheet E-3, Part IV)				22
23	Subtotal (sum of lines 19 through 22)			272	23
24	Primary payer payments				24
25	Subtotal (line 23 minus line 24)			272	25
	Reimbursable bad debts (exclude bad debts for professional services)				
26	Composite rate ESRD (from Worksheet I-5, line 9)				26
27	Bad debts (see instructions)				27
27.01	Adjusted reimbursable bad debts (see instructions)				27.01
27.02	Reimbursable bad debts for dual eligible beneficiaries				27.02
28	Subtotal (sum of lines 25, 26, and 27 or 27.01) (line 27.01 hospital and subprovider only)			272	28
29	Recovery of excess depreciation resulting from provider termination or a decrease in program utilization				29
30	Other adjustments (specify) (see instructions)				30
31	Amounts applicable to prior cost reporting periods resulting from disposition of depreciable assets				31
32	Subtotal (line 28 plus or minus lines 30 and 31 minus line 29)			272	32
33	Sequestration adjustment (see instructions)				33
34	Interim payments			272	34
34.01	Tentative settlement (for fiscal intermediary use only)				34.01
35	Balance due provider/program (line 32 minus the sum of ilnes 33, 34, and 34.01)				35
36	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2				36
TO BE COMPLETED BY CONTRACTOR					
50	Original outlier amount (see instructions)				50
51	Outlier reconciliation amount (see instructions)				51

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	CALCULATION OF REIMBURSEMENT SETTLEMENT	PROVIDER NO: 420087	PERIOD: FROM 01/01/2010 TO 12/31/2010	WORKSHEET E PART B	
Medicare -Title XVIII - Subprovider 1 - 42T087					
52	The rate used to calculate the Time Value of Money				52
53	Time Value of Money (see instructions)				53
54	Total (sum of lines 51 and 53)				54

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	CALCULATION OF REIMBURSEMENT SETTLEMENT	PROVIDER NO: 420087	PERIOD: FROM: 01/01/2010 TO: 12/31/2010	WORKSHEET E-3 PART 1	
Medicare -Title XVIII - Subprovider 1 - 42T087					
PART I - MEDICARE PART A SERVICES - TEFRA AND IRF PPS, LTCH PPS AND IPF PPS					
1	Inpatient hospital services (see instructions)				1
1.01	Hospital specific amount (see instructions)				1.01
1.02	Net Federal PPS Payments (see instructions)			8,334,018	1.02
1.03	Medicare SSI ratio (IRF PPS only) (see instructions)			0.057800	1.03
1.04	Inpatient Rehabilitation LIP payment (see instructions)			435,636	1.04
1.05	Outlier Payments			534,461	1.05
1.06	Total PPS Payments {sum of lines 1.01, (1.02, 1.04, 1.42 for columns 1 and 1.01), and 1.05}			9,304,115	1.06
1.07	Nursing Allied Health Managed Care Payments				1.07
Inpatient Psychiatric Facility (IPF)					
1.08	Net Federal IPF PPS Payments (excluding outlier, ECT, scenterloss, and medical education payments)				1.08
1.09	Net IPF PPS Outlier Payments				1.09
1.10	Net IPF PPS ECT Payments				1.10
1.11	Unweighted intern and resident FTE count for latest cost report filed prior to November 15, 2004. (see instructions)				1.11
1.12	New Teaching program adjustment. (see instructions)				1.12
1.13	Current years unweighted FTE count of I&R other than FTEs in the first 3 years of a new teaching program. (see inst.)				1.13
1.14	Current years unweighted I&R FTE count for residents within the first 3 years of a new teaching program. (see inst.)				1.14
1.15	Intern and resident count for IPF PPS medical education adjustment (see instructions)				1.15
1.16	Average Daily Census (see instructions)				1.16
1.17	Medical Education Adjustment Factor {((1 + (line 1.15/line 1.16)) raised to the power of .5150 -1}.				1.17
1.18	Medical Education Adjustment (line 1.08 multiplied by line 1.17).				1.18
1.19	Adjusted Net IPF PPS Payments (sum of lines 1.08, 1.09, 1.10 and 1.18)				1.19
1.20	Scenter Loss Payment Floor (line 1 x 70%).				1.20
1.21	Adjusted Net Payment Floor (line 1.20 x the appropriate Federal blend percentage)				1.21
1.22	Scenter Loss Adjustment (If line 1.21 is greater than line 1.19 enter the amount on line 1.21 less line 1.19 otherwise enter -0-)				1.22
1.23	Total IPF PPS Payments (sum of lines 1.01, 1.19 and 1.22)				1.23
Inpatient Rehabilitation Facility (IRF)					
1.35	Unweighted intern and resident FTE count for cost report periods ending on/or prior to November 15, 2004. (see inst.)				1.35
1.36	New Teaching program adjustment. (see instructions)				1.36
1.37	Current years unweighted FTE count of I&R other than FTEs in the first 3 years of a new teaching program. (see inst.)				1.37
1.38	Current years unweighted I&R FTE count for residents within the first 3 years of a new teaching program. (see inst.)				1.38
1.39	Intern and resident count for IRF PPS medical education adjustment (see instructions)				1.39
1.40	Average Daily Census (see instructions)			38.46	1.40
1.41	Medical Education Adjustment Factor (see instructions).				1.41
1.42	Medical Education Adjustment (line 1.02 multiplied by line 1.41).				1.42
2	Organ acquisition				2
3	Cost of teaching physicians (from Worksheet D-9, Part II, column 3, line 16) (see instructions)				3
4	Subtotal (sum of lines 1.06, 2, and 3)			9,304,115	4
5	Primary payer payments			8,688	5
6	Subtotal (line 4 less line 5)			9,295,427	6
7	Deductibles			84,668	7
8	Subtotal (line 6 minus line 7)			9,210,759	8
9	Coinsurance			84,700	9
10	Subtotal (line 8 minus line 9)			9,126,059	10
11	Reimbursable bad debts (exclude bad debts for professional services) (see instructions)				11
11.01	Adjusted reimbursable bad debts (see instructions)				11.01
11.02	Reimbursable bad debts for dual eligible beneficiaries				11.02
12	Subtotal (sum of lines 10 and 11.01)			9,126.059	12
13	Direct graduate medical education payment (from Worksheet E-3, Part IV, line 24)				13
13.01	Other pass through costs (see instructions)			13,267	13.01
14	Recovery of excess depreciation resulting from provider termination or a decrease in program				14

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	CALCULATION OF REIMBURSEMENT SETTLEMENT	PROVIDER NO: 420087	PERIOD: FROM: 01/01/ 2010 TO: 12/31/2010	WORKSHEET E-3 PART 1	
Medicare -Title XVIII - Subprovider 1 - 42T087					
PART I - MEDICARE PART A SERVICES - TEFRA AND IRF PPS, LTCH PPS AND IPF PPS					
15	Other adjustments (see instructions) (specify)				15
16	Amounts applicable to prior cost reporting periods resulting from disposition of depreciable a				16
17	Total amount payable to the provider (see instructions)			9,139,326	17
18	Sequestration adjustment (see instructions)				18
19	Interim payments			8,909,608	19
19.01	Tentative settlement (for fiscal intermediary use only)				19.01
20	Balance due provider/program (line 17 minus the sum of lines 18, 19, and 19.01)			229,718	20
21	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section				21
TO BE COMPLETED BY INTERMEDIARY					
50	Operating outlier amount from Worksheet E-3, Part I line 1.05 or line 1.09				50
51	Operating Outlier reconciliation amount (see instructions)				51
52	The interest rate used to calculate the Time Value of Money				52
53	Operating Time Value of Money (see instructions)				53

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	CALCULATION OF REIMBURSEMENT SETTLEMENT	PROVIDER NO: 420087	PERIOD: FROM: 01/01/2010 TO: 12/31/2010	WORKSHEET E-3 PART III	
Medicaid - Title XIX - Hospital - 420087					
	COMPUTATION OF NET COST OF COVERED SERVICES		Title V or Title XIX	Title XVIII SNF PPS	
			1	2	
1	Inpatient hospital/SNF/NF services		8,152,073		1
2	Medical and other services		3,043,335		2
3	Interns and residents (see instructions)				3
4	Organ acquisition (certified transplant centers only)				4
5	Cost of teaching physicians (see instructions)				5
6	Subtotal (sum of lines 1 through 5)		11,195,408		6
7	Inpatient primary payer payments				7
8	Outpatient primary payer payments				8
9	Subtotal (line 6 less sum of lines 7 and 8)		11,195,408		9
COMPUTATION OF LESSER OF COST OR CHARGES					
	REASONABLE CHARGES				
10	Routine service charges				10
11	Ancillary service charges		31,325,349		11
12	Interns and residents service charges				12
13	Organ acquisition charges, net of revenue				13
14	Teaching physicians				14
15	Incentive from target amount computation				15
16	Total reasonable charges (sum of lines 10 through 15)		31,325,349		16
	CUSTOMARY CHARGES				
17	Amount actually collected from patients liable for payment for services on a charge basis				17
18	Amounts that would have been realized from patients liable for payment for a on charge basis had such payment been made in accordance with 42 CFR 4				18
19	Ratio of line 17 to line 18 (not to exceed 1.000000)				19
20	Total customary charges (see instructions)		31,325,349		20
21	Excess of customary charges over reasonable cost (complete only if line 20 exceeds line 9) (see instructions)		20,129,941		21
22	Excess of reasonable cost over customary charges (complete only if line 9 exceeds line 20) (see instructions)				22
23	Cost of covered services (line 9)		11,195,408		23
24	Other than outlier payments				24
25	Outlier payments				25
26	Program capital payments				26
27	Capital exception payments				27
28	Routine service other pass through costs				28
29	Ancillary service other pass through costs				29
30	Subtotal (sum of lines 23 through 29)		11,195,408		30
31	Customary charges (title XIX PPS covered services only)				31
32	Titles V or XIX PPS, lesser of lines 30 or 31; non PPS and title XVIII enter a		11,195,408		32
33	Deductibles (exclude professional component)				33
34	Excess of reasonable cost (from line 22)				34
35	Subtotal (line 32 minus sum of lines 33 and 34)		11,195,408		35
36	Coinsurance				36
37	Sum of the amounts from Wkst. E, Parts C, D, and E, line 19				37
38	Reimbursable bad debts (see instructions)				38
38.01	Adjusted reimbursable bad debts (see instructions)				38.01
38.02	Reimbursable bad debts for dual eligible beneficiaries				38.02
38.03	Adjusted reimbursable bad debts for periods ending on or after 10/01/05 (see instructions)				38.03
39	Utilization review				39
40	Subtotal (see instructions)		11,195,408		40
41	Inpatient routine service cost (Wkst. D-1, Part III, line 70)				41
42	Medicare inpatient routine charges (from your records)				42
43	Amount actually collected from patients liable for payment for services on a charge basis (see instructions)				43
44	Amounts that would have been realized from patients liable for payment of Part A services (see instructions)				44
45	Ratio of line 43 to line 44 (not to exceed 1.000000)				45
46	Total customary charges (see instructions)				46

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	CALCULATION OF REIMBURSEMENT SETTLEMENT	PROVIDER NO: 420087	PERIOD: FROM: 01/01/2010 TO: 12/31/2010	WORKSHEET E-3 PART III	
Medicaid - Title XIX - Hospital - 420087					
	COMPUTATION OF NET COST OF COVERED SERVICES		Title V or Title XIX	Title XVIII SNF PPS	
			1	2	
47	Excess of customary charges over reasonable cost (see instructions)				47
48	Excess of reasonable cost over customary charges (see instructions)				48
49	Recovery of excess depreciation resulting from provider termination or a decrease in program utilization				49
50	Other adjustments (see instructions) (specify)				50
51	Amounts applicable to prior cost reporting periods resulting from disposition of depreciable assets				51
52	Subtotal (line 40 ± lines 50 and 51, minus line 49)		11,195,408		52
53	Indirect medical education adjustment (PPS only) (see instructions)				53
54	Direct graduate medical education payments (from Wkst. E-3, Part IV)				54
55	Total amount payable to the provider (sum of lines 52, 53, and 54)		11,195,408		55
56	Sequestration adjustment (see instructions)				56
57	Interim payments		10,619,116		57
57.01	Tentative settlement (for fiscal intermediary use only)				57.01
58	Balance due provider/program (line 55 minus the sum of lines 56, 57, and 57.01)		576,292		58
59	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2				59

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BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)		PROVIDER NO: 420087	PERIOD: FROM 01/01/2010 TO 12/31/2010	WORKSHEET G	
	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	1	2	3	4	
	CURRENT ASSETS				
1	Cash on hand and in banks	43,253			1
2	Temporary investments				2
3	Notes receivable				3
4	Accounts receivable	59,864,363			4
5	Other receivables	3,011,500			5
6	Allowances for uncollectible notes and accounts receivable				6
7	Inventory	6,678,847			7
8	Prepaid expenses	1,030,868			8
9	Other current assets				9
10	Due from other funds	88,313,992			10
11	Total current assets (sum of lines 1-10)	158,942,823			11
	FIXED ASSETS				
12	Land	3,872,178			12
13	Land improvements	2,600,031			13
13.01	Accumulated depreciation	1,606,013			13.01
14	Buildings	219,329,258			14
14.01	Accumulated depreciation	109,475,774			14.01
15	Leasehold improvements	5,761,734			15
15.01	Accumulated depreciation	2,064,364			15.01
16	Fixed equipment	1,780,252			16
16.01	Accumulated depreciation	1,015.617			16.01
17	Automobiles and trucks				17
17.01	Accumulated depreciation				17.01
18	Major movable equipment	96,888,351			18
18.01	Accumulated depreciation	52,883,298			18.01
19	Minor equipment depreciable				19
19.01	Accumulated depreciable				19.01
20	Minor equipment-nondepreciable				20
21	Total fixed assets (sum of lines 12-20)	163,186,738			21
	OTHER ASSETS				
22	Investments	-474,156			22
23	Deposits on leases				23
24	Due from owners/officers				24
25	Other assets	17,032,208			25
26	Total other assets (sum of lines 22-25)	16,558,052			26
27	Total assets (sum of lines 11, 21, and 26)	338,687,613			27
	CURRENT LIABILITIES				
28	Accounts payable	1,927,225			28
29	Salaries, wages, and fees payable				29
30	Payroll taxes payable				30
31	Notes and loans payable (short term)	509,720			31
32	Deferred income				32
33	Accelerated payments				33
34	Due to other funds	-146,019,333			34
35	Other current liabilities	10,860,948			35
36	Total current liabilities (sum of lines 28 thru 35)	-132.721,440			36
	LONG TERM LIABILITIES				

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BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)			PROVIDER NO: 420087	PERIOD: FROM 01/01/2010 TO 12/31/2010	WORKSHEET G	
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1	2	3	4	
37	Mortgage payable					37
38	Notes payable	1,985,867				38
39	Unsecured loans					39
40	Loans from owners 40.01 Prior to 7/1/66 40.02 On or after 7/1/66					40.01
						40.02
41	Other long term liabilities	1,068,333				41
42	Total long term liabilities (sum of lines 37 thru 41)	3,054,200				42
43	Total liabilities (sum of lines 36 and 42)	-129,667,240				43
	CAPITAL ACCOUNTS					
44	General fund balance	468,354,853				44
45	Specific purpose fund					45
46	Donor created - endowment fund balance - restricted					46
47	Donor created - endowment fund balance - unrestricted					47
48	Governing body created - endowment fund balance					48
49	Plant fund balance - invested in plant					49
50	Plant fund balance - reserve for plant improvement, replacement, and expansion					50
51	Total fund balances (sum of lines 44 thru 50)	468,354,853				51
52	Total liabilities and fund balances (sum of lines 43 and 51)	338,687,613				52

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STATEMENT OF PATIENT REVENUES AND OPERATING REVENUES	PROVIDER NO: 420087	PERIOD: FROM 01/01/2010 TO 12/31/2010	WORKSHEET G-2 PARTS I & II	
PART I - PATIENT REVENUES				
REVENUE CENTER	INPATIENT	OUTPATIENT	TOTAL	
	1	2	3	
GENERAL INPATIENT ROUTINE CARE SERVICES				
1 Hospital	107,550,093		107,550,093	1
2.00 SubComponent 1 - 42T087	19,599,929		19,599,929	2.00
4 Swing bed - SNF				4
5 Swing bed - NF				5
6 Skilled nursing facility				6
7 Nursing facility				7
8 Other long term care				8
9 Total general inpatient care services (sum of lines 1-8)	127,150,022		127,150,022	9
INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
10 Intensive care unit	29,680,309		29,680,309	10
11 Coronary care unit				11
12 Burn intensive care unit				12
13 Surgical intensive care unit				13
14.00 Other Special Care (specify)				14.00
15 Total intensive care type inpatient hospital services (sum of lines 10-14)	29,680,309		29,680,309	15
16 Total inpatient routine care services (sum of lines 9 and 15)	156,830,331		156,830,331	16
17 Ancillary services	424,222,909		424,222,909	17
18 Outpatient services		602,182,327	602,182,327	18
19 Home health agency		7,864,666	7,864,666	19
20 Ambulance	1,594,520	2,462,973	4,057,493	20
21 Outpatient rehabilitation providers				21
22 ASC				22
23 Hospice				23
24	947,787	2,660,913	3,608,700	24
25 Total patient revenues (sum of lines 16-24) (transfer column 3 to Wkst. G-3, line 1)	583,595,547	615,170,879	1,198,766,426	25
PART II - OPERATING EXPENSES				
		1	2	
26 Operating expenses (per Wkst. A, column 3, line 101)			339,725,421	26
27 Add (specify)				27
28				28
29				29
30				30
31				31
32				32
33 Total additions (sum of lines 27-32)				33
34 Deduct (specify)				34
35				35
36				36
37				37
38				38
39 Total deductions (sum of lines 34-38)			1	39
40 Total operating expenses (sum of lines 26 and 33 minus line 39) (transfer to Wkst. G-3, line 4)			339,725,420	40

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STATEMENT OF REVENUES AND EXPENSES	PROVIDER NO: 420087	PERIOD: FROM 01/01/2010 TO 12/31/2010	WORKSHEET G-3	
	Description			
1	Total patient revenues (from Wkst. G-2, Part I, column 3, line 25)		1,198.766,426	1
2	Less contractual allowances and discounts on patients' accounts		807,079,775	2
3	Net patient revenues (line 1 minus line 2)		391,686,651	3
4	Less total operating expenses (from Wkst. G-2, Part II, line 40)		339,725,420	4
5	Net income from service to patients (line 3 minus line 4)		51,961,231	5
OTHER INCOME				
6	Contributions, donations, bequests, etc.			6
7	Income from investments			7
8	Revenues from telephone and telegraph service			8
9	Revenue from television and radio service			9
10	Purchase discounts			10
11	Rebates and refunds of expenses			11
12	Parking lot receipts			12
13	Revenue from laundry and linen service			13
14	Revenue from meals sold to employees and guests		1,902,051	14
15	Revenue from rental of living quarters			15
16	Revenue from sale of medical and surgical supplies to other than patients			16
17	Revenue from sale of drugs to other than patients			17
18	Revenue from sale of medical records and abstracts		17,009	18
19	Tuition (fees, sales of textbooks, uniforms, etc.)			19
20	Revenue from gifts, flowers, coffee shops, and canteen			20
21	Rental of vending machines			21
22	Rental of hospital space			22
23	Governmental appropriations			23
24	Other (specify)		2,710,853	24
25	Total other income (sum of lines 6-24)		4,629,913	25
26	Total (line 5 plus line 25)		56,591,144	26
27	Other expenses (specify)			27
28				28
29				29
30	Total other expenses (sum of lines 27-29)			30
31	Net income (or loss) for the period (line 26 minus line 30)		56,591,144	31

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Medicare - Title XVIII - HHA 1 - 427042

APPORTIONMENT OF PATIENT SERVICE COSTS | PROVIDER NO: 420087 | PERIOD: FROM: 01/01/2010 TO 12/31/2010 | WORKSHEET H-6

PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION

Cost Per Visit Computation Patient Services		From Wkst H-5 Part I col 29, line	Facility Costs (from Wkst H-5 Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs(cols 1 + 2)	Total Visits	Average Cost Per Visit (col 3 ÷ col 4	Program Visits			Cost of Services			Total Program Cost(sum of cols 9-10)	
								Part A	Part B		Part A	Part B			
									Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
			1	2	3	4	5	6	7	8	9	10	11	12	
1	Skilled Nursing Care	2	3,549,356		3,549,356	18,399	192.91	7,247	4,639		1,398,019	894,909		2,292,928	1
2	Physical Therapy	3	3,913,699		3,913,699	24,852	157.48	10,264	6,723		1,616,375	1,058,738		2,675,113	2
3	Occupational Therapy	4	896,298		896,298	6,241	143.61	3,164	1,229		454,382	176,497		630,879	3
4	Speech Pathology	5	287,515		287,515	1,167	246.37	493	188		121,460	46,318		167,778	4
5	Medical Social Services	6	271,017		271,017	414	654.63	105	101		68,736	66,118		134,854	5
6	Home Health Aide	7	240,459		240,459	3,331	72.19	1,295	1,731		93,486	124,961		218,447	6
7	Total (sum of lines 1-6)		9,158,344		9,158,344	54,404		22,568	14,611		3,752,458	2,367,541		6,119,999	7

Limitation Cost Computation Patient Services		MSA NO (1)				Program Cost Limits	Program Visits			Cost of Services			Total Program Cost(sum of cols 9-10	
							Part A	Part B		Part A	Part B			
								Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
		1	2	3	4	5	6	7	8	9	10	11	12	
8	Skilled Nursing Care													8
9	Physical Therapy													9
10	Occupational Therapy													10
11	Speech Pathology													11
12	Medical Social Services													12
13	Home Health Aide													13
14	Total (sum of lines 8-13)													14

Supplies and Drugs Cost Computations Other Patient Services		From Wkst H-5,Part I, col 29, line	Facility costs (from Wkst, H-5, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols 1 + 2)	Total Charges (from HHA Record)	Ratio (col 3 ÷ col 4)	Program Covered Charges			Cost of Services			
								Part A	Part B		Part A	Part B		
									Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
			1	2	3	4	5	6	7	8	9	10	11	
15	Cost of Medical Supplies	8			254,222	319,941	0.794590	101,563	109,834		80,701	87,273		15
16	Cost of Drugs	9												16

Per Beneficiary Cost Limitation:		MSA No. (1)	Amount	
17	Program unduplicated census from Worksheet S-4 (see instructions) (2)			17
18	Per beneficiary cost limitation (from your fiscal intermediary)			18
19	Per beneficiary cost limitation (line 17 times line 18) (see instructions)			19

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Medicare -Title XVIII - HHA 1 - 427042

APPORTIONMENT OF PATIENT SERVICE COSTS	PROVIDER NO: 420087	PERIOD: FROM. 01/01/2010 TO: 12/31/2010	WORKSHEET H-6

(1) The MSA numbers flow from Worksheet S-4, line 20, and subscripts as indicated should be relicated on lines 8-13 and 17-18.

(2) The sum of line 17 and subscripts thereof must equal Worksheet S-4, line 2, for the appropriate title.

PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS

		From Wkst C, Part I col 9, Line	Cost to Charge Ratio	Total HHA Charges (from provider records)	HHA Shared Ancillary Costs Col. 1 × col2)	Transfer to Part I as Indicated	
			1	2	3	4	
1	Physical Therapy	50				col. 2, line 2	1
2	Occupational Therapy	51				col. 2, line 3	2
3	Speech Pathology	52				col. 2, line 4	3
4	Cost of Medical Supplies	55				col. 2, line 15	4
5	Cost of Drugs	56				col. 2, line 16	5

PART III - OUTPATIENT THERAPY REDUCTION COMPUTATION

		From Part I, Col 5	Part B Services Subject to Deductibles and Coinsurance					
			Cost Per Visit	Program Visits		Program Costs		Program Visits on or after 1/1/1999
				Prior to 1/1/1998	From 1/1/1998 thou 12/31/1998	Prior to 1/1/1998	From 1/1/1998 thou 12/31/1998	
		1	2	2.01	3	3.01	4	5
1	Physical Therapy	2	157.48						1
2	Occupational Therapy	3	143.61						2
3	Speech Pathology	4	246.37						3
4	Total (sum of lines 1-3)								4

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ROPER HOSPITAL - CHARLESTON, SC
Cost report status - As Submitted
[Record code 268372 - 1996]

Medicaid - Title XIX - HHA 1 - 427042

APPORTIONMENT OF PATIENT SERVICE COSTS	PROVIDER NO: 420087	PERIOD: FROM: 01/01/2010 TO: 12/31/2010	WORKSHEET H-6

PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION

Cost Per Visit Computation Patient Services	From Wkst H-5 Part I col 29,	Facility Costs (from Wkst H-5 Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs(cols 1 + 2)	Total Visits	Average Cost Per Visit (col 3 ÷ col 4	Program Visits			Cost of Services			Total Program Cost(sum of cols 9-10)	
							Part A	Part B		Part A	Part B			
								Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
	line	1	2	3	4	5	6	7	8	9	10	11	12	
1 Skilled Nursing Care	2	3,549,356		3,549,356	18,399	192.91								1
2 Physical Therapy	3	3,913,699		3,913,699	24,852	157.48								2
3 Occupational Therapy	4	896,298		896,298	6,241	143.61								3
4 Speech Pathology	5	287,515		287,515	1,167	246.37								4
5 Medical Social Services	6	271,017		271,017	414	654.63								5
6 Home Health Aide	7	240,459		240,459	3,331	72.19								6
7 Total (sum of lines 1-6)		9,158,344		9,158,344	54,404									7

Limitation Cost Computation Patient Services	MSA NO (1)				Program Cost Limits	Program Visits			Cost of Services			Total Program Cost(sum of cols 9-10	
						Part A	Part B		Part A	Part B			
							Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
	1	2	3	4	5	6	7	8	9	10	11	12	
8 Skilled Nursing Care													8
9 Physical Therapy													9
10 Occupational Therapy													10
11 Speech Pathology													11
12 Medical Social Services													12
13 Home Health Aide													13
14 Total (sum of lines 8-13)													14

Supplies and Drugs Cost Computations Other Patient Services	From Wkst H-5,Part I, col 29, line	Facility costs (from Wkst, H-5, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols 1 + 2)	Total Charges (from HHA Record)	Ratio (col 3 ÷ col 4)	Program Covered Charges			Cost of Services			
							Part A	Part B		Part A	Part B		
								Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		1	2	3	4	5	6	7	8	9	10	11	
15 Cost of Medical Supplies	8			254,222									15
16 Cost of Drugs	9												16

Per Beneficiary Cost Limitation:	MSA No. (1)	Amount	
17 Program unduplicated census from Worksheet S-4 (see instructions) (2)			17
18 Per beneficiary cost limitation (from your fiscal intermediary)			18
19 Per beneficiary cost limitation (line 17 times line 18) (see instructions)			19

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Medicaid - Title XIX - HHA 1 - 427042			
APPORTIONMENT OF PATIENT SERVICE COSTS	PROVIDER NO 420087	PERIOD: FROM: 01/01/2010 TO: 12/31/2010	WORKSHEET H-6

(1) The MSA numbers flow from Worksheet S-4, line 20, and subscripts as indicated should be relicated on lines 8-13 and 17-18.

(2) The sum of line 17 and subscripts thereof must equal Worksheet S-4, line 2, for the appropriate title.

PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS

		From Wkst C, Part I col 9, Line	Cost to Charge Ratio	Total HHA Charges (from provider records)	HHA Shared Ancillary Costs Col. 1 × col2)	Transfer to Part I as Indicated	
			1	2	3	4	
1	Physical Therapy	50				col. 2, line 2	1
2	Occupational Therapy	51				col. 2, line 3	2
3	Speech Pathology	52				col. 2, line 4	3
4	Cost of Medical Supplies	55				col. 2, line 15	4
5	Cost of Drugs	56				col. 2, line 16	5

PART III - OUTPATIENT THERAPY REDUCTION COMPUTATION

		From Part I, Col 5	Part B Services Subject to Deductibles and Coinsurance					
			Cost Per Visit	Program Visits		Program Costs		Program Visits on or after 1/1/1999
				Prior to 1/1/1998	From 1/1/1998 thou 12/31/1998	Prior to 1/1/1998	From 1/1/1998 thou 12/31/1998	
		1	2	2.01	3	3.01	4	5
1	Physical Therapy	2							1
2	Occupational Therapy	3							2
3	Speech Pathology	4							3
4	Total (sum of lines 1-3)								4

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ROPER HOSPITAL - CHARLESTON, SC
Cost report status - As Submitted
[Record code 268372 - 1996]

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT	PROVIDER NO: 420087	PERIOD: FROM: 01/01/2010 TO. 12/31/2010	WORKSHEET H-7 Parts I & II

Medicare -Title XVIII - HHA 1 - 420087

PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES

	Description	Part A	Part B		
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		1	2	3	
Reasonable Cost of Part A & Part B Services					
1	Reasonable cost of services (see instructions)				1
2	Total charges				2
	Customary Charges				
3	Amount actually collected from patients liable for payment for services on a charge basis (from your records)				3
4	Amount 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(b)				4
5	Ratio of line 3 to line 4 (not to exceed 1.000000)				5
6	Total customary charges (see instructions)				6
7	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)				7
8	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)				8
9	Primary payer amounts				9

PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT

	Description	Part A Services	Part B Services	
		1	2	
10	Total reasonable cost (see instructions)			10
10.01	Total PPS Reimbursement - Full Episodes without Outliers	4,239,867	2,817,324	10.01
10.02	Total PPS Reimbursement - Full Episodes with Outliers	13,199	9,587	10.02
10.03	Total PPS Reimbursement - LUPA Episodes	43,136	47,152	10.03
10.04	Total PPS Reimbursement - PEP Episodes	37,128	18,321	10.04
10.05	Total PPS Reimbursement - SCIC within a PEP Episodes			10.05
10.06	Total PPS Reimbursement - SCIC Episodes			10.06
10.07	Total PPS Outlier Reimbursement - Full Episodes with Outliers	4,288	1,863	10.07
10.08	Total PPS Outlier Reimbursement - PEP Episodes			10.08
10.09	Total PPS Outlier Reimbursement - SCIC within a PEP Episodes			10.09
10.10	Total PPS Outlier Reimbursement - SCIC Episodes			10.10
10.11	Total Other Payments			10.11
10.12	DME Payments			10.12
10.13	Oxygen Payments			10.13
10.14	Prosthetic and Orthotic Payments			10.14
11	Part B deductibles billed to Medicare patients (exclude coinsurance)			11
12	Subtotal (sum of lines 10 thru 10.14 minus line 11)	4,337,618	2,894,247	12
13	Excess reasonable cost (from line 8)			13
14	Subtotal (line 12 minus line 13)	4,337,618	2,894,247	14
15	Coinsurance billed to program patients (from your records)			15
16	Net cost (line 14 minus line 15)	4,337,618	2,894,247	16
17	Reimbursable bad debts (from your records)			17
17.01	Reimbursable bad debts for dual eligible beneficiaries			17.01
18	Total costs - current cost reporting period (line 16 plus line 17)	4,337,618	2,894,247	18
19	Amounts applicable to prior cost reporting periods resulting from disposition of depreciable assets			19
20	Recovery of excess depreciation resulting from agencies' termination or decrease in program utilization			20
21	Other adjustments (see instructions) (specify)			21
22	Subtotal (line 18 plus/minus lines 19 and 21 minus line 20)	4,337,618	2,894,247	22
23	Sequestration adjustment (see instructions)			23
24	Subtotal (line 22 minus line 23)	4,337,618	2,894,247	24
25	Interim payments (see instructions)	4,337,618	2,894,247	25
25.01	Tentative settlement (for fiscal intermediary use only)			25.01
26	Balance due provider/program (line 24 minus lines 25 and 25.01)			26
27	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			27

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ROPER HOSPITAL - CHARLESTON, SC
Cost report status - As Submitted
[Record code 268372 - 1996]

Medicare -Title XVIII - Hospital - 420087				
CALCULATION OF CAPITAL PAYMENT	PROVIDER NO: 420087	PERIOD: FROM: 01/01/2010 TO: 12/31/2010	WORKSHEET L	
PART I - FULLY PROSPECTIVE METHOD				
1	Capital hospital specific rate payments			1
	Capital Federal Amount			
2	Capital DRG other than outlier		5,167,038	2
3	Capital DRG outlier payments for services rendered prior to October 1, 1997			3
3.01	Capital DRG outlier payments for services rendered on or after October 1, 1997		239,985	3.01
	Indirect Medical Education Adjustment			
4	Total inpatient days divided by number of days in the cost reporting period (see instructions)		196.37	4
4.01	Number of interns & residents (from Worksheet S-3, Part I, column 9, line 12)			4.01
4.02	Indirect medical education percentage (see instructions)			4.02
4.03	Indirect medical education adjustment (sum of lines 2 & 3 times line 4.02)			4.03
	Disproportionate Share Adjustment			
5	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		0	5
5.01	Percentage of Medicaid patient days to total days reported on Worksheet S-3, Part I (see instructions)		0.096100	5.01
5.02	Sum of lines 5 and 5.01		0.19	5.02
5.03	Allowable disproportionate share percentage (see instructions)		0.038700	5.03
5.04	Disproportionate share adjustment (sum of lines 2 & 3 times line 5.03)		199,964	5.04
6	Total prospective capital payments (sum of lines 1-3.01, 4.03, and 5.04)		5,606,987	6
PART II - HOLD HARMLESS METHOD				
1	New capital (see instructions)			1
2	Old capital (see instructions)			2
3	Total capital (sum of line 1 plus line 2)			3
4	Ratio of new capital to total capital (line 1 divided by line 3)			4
5	Total capital payments under 100% federal rate (see instructions)			5
6	Reduction factor for hold harmless payment (see instructions)			6
7	Reduced old capital amount (line 2 x line 6)			7
8	Hold harmless payment for new capital (line 5 x line 4)			8
9	Subtotal (line 7 plus line 8)			9
10	Payment under hold harmless (greater of line 5 or line 9)			10
PART III - PAYMENT UNDER REASONABLE COST				
1	Program inpatient routine capital cost (see instructions)			1
2	Program inpatient ancillary capital cost (see instructions)			2
3	Total inpatient program capital cost (line 1 plus line 2)			3
4	Capital cost payment factor (see instructions)			4
5	Total inpatient program capital cost (line 3 x line 4)			5
PART IV - COMPUTATION OF EXCEPTION PAYMENTS				
1	Program inpatient capital costs (see instructions)			1
2	Program inpatient capital costs for extraordinary circumstances (see instructions)			2
3	Net program inpatient capital costs (line 1 minus line 2)			3
4	Applicable exception percentage (see instructions)			4
5	Capital cost for comparison to payments (line 3 x line 4)			5
6	Percentage adjustment for extraordinary circumstances (see instructions)			6
7	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)			7
8	Capital minimum payment level (line 5 plus line 7)			8
9	Current year capital payments (from Part I, line 6 or Part II, line 10, as applicable)			9
10	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)			10
11	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part IV, line 14)			11
12	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)			12
13	Current year exception payment (if line 12 is positive, enter the amount on this line) for the following period (if line 12 is negative, enter the amount on this line)			13
14	Carryover of accumulated capital minimum payment level over capital payment			14
15	Current year allowable operating and capital payment (see instructions)			15
16	Current year operating and capital costs (see instructions)			16
17	Current year exception offset amount			17

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Cost Report data

420087
ROPER HOSPITAL
316 CALHOUN ST
CHARLESTON, SC 29401

[Electronic Record Code: 7200 - 2010]
Type of Facility: Short Term Acute Care
Type of Control: Voluntary Nonprofit, Other
Classification: Urban

Bed Size:	316
Total Annual Discharges:	14,255
Total Patient Revenue:	$1,229,131,520

Period: 01/01/2011 - 12/31/2011
Status: As Submitted

Fiscal Intermediary: Palmetto Government Benefits Administrators

Medicare Inpatient Characteristics

DSH Ratio:	0.037700
DSH Amount:	$2,376,237
Outlier Amount:	$2,810,537
IME Amount:	$0
GME Amount:	$0
Total IP Reimbursement:	$85,306,289
Total IP Costs:	$92,858,664
NPR Date:	00/00/0000
NPR Settlement Amount:	$68,048,015
NPR Settlement Percent:	79.77 %

[Date Generated: 03/20/2013]

Source
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Please note that CostReportData.com worksheets are replicated from electronic cost report data obtained from the CMS Healthcare Cost Report Information System dataset (HCRIS) and may differ from the format submitted by the hospital (e.g. sub-lines and sub-columns may be combined, certain totals have been calculated, etc.). Also, please note that some worksheets may not be included because data are not available from the CMS HCRIS file or because the worksheets are seldom used. Cost reports for periods beginning May 1, 2010 are based on a new 2552-10 format and sometimes contain ambiguities in the assignment of some cost centers as submitted by a hospital. Whenever such ambiguities are overridden you will see an explanation at the top of all affected worksheets.

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Legend:

Identification
A hospital's Medicare provider number, name, and address are taken from Worksheet S-2. The Electronic Code is a code assigned by CostReportData.com to assist in resolving questions.

Type of Facility
The type of facility is determined from the last four digits of its Medicare provider number.

Type of Control
A hospital's type of control is taken from the HCRIS file.

Bed Size
The number of staffed beds is taken from Worksheet S-3, Part I, line 12, col.1. Cost report instructions define staffed beds as, "the number of beds available for use by patients at the end of the cost reporting period. A bed means an adult bed, pediatric bed, birthing room, or newborn bed maintained in a patient care area for lodging patients in acute, long term, or domiciliary areas of the hospital. Beds in labor room, birthing room, postanesthesia, postoperative recovery rooms, outpatient areas, emergency rooms, ancillary departments, nurses' and other staff residences, and other such areas which are regularly maintained and utilized for only a portion of the stay of patients (primarily for special procedures or not for inpatient lodging) are not termed a bed for these purposes.

Total Annual Discharges
The total number of inpatient discharges (all payors) is taken from Worksheet S-3, part I, line 12, column 15.

Total Patient Revenue
The total patient revenue (inpatient and outpatient) is taken from Worksheet G-2, part I, line 25, column 3.

Period
The beginning and ending dates for a cost report are taken from Worksheet S-2, line 17.

Status
The status of a cost report is taken from the HCRIS file.

Fiscal Intermediary
Medicare Fiscal Intermediaries (FIs) are private insurance companies that serve as the federal government's agents in the administration of the Medicare program, including the payment of claims. The name of the FI is obtained from a hospital's most recent Medicare cost report.

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Disproportionate Share (DSH Amount and DSH Ratio)
Medicare provides additional payment to hospitals that treat a disproportionate share of low-income patients. Qualifying hospitals receive a percentage increase in Medicare payments. This percentage increase varies depending on the ratio of low income patients and on certain statutory calculations. The Disproportionate SHare (DSH) ratio is taken from Worksheet E, Part A, line 4.03. The amount of DSH payments is from Worksheet E, Part A, line 4.04.

Outlier Amount
Medicare makes additional payments to hospitals for patients with costs that are extraordinarily high due to severity of illness and/or complicating conditions. The amount of outlier payments is from Worksheet E, Part A, line 2.01 (or line 2 for discharges occurring prior to October 1, 1997).

IME Amount
Teaching hospitals receive additional Medicare payment due to the indirect costs associated with medical education programs. These payments are intended to cover the costs of additional tests and procedures ordered by interns and residents over and above what would have been ordered by more experienced physicians. The amount of the Indirect Medical Education (IME) adjustment is from Worksheet E, Part A, line 3.24 (or line 3.03 for cost reporting periods ending on or before September 30, 1997).

GME Amount
Medicare pays a hospital for the costs of an approved direct Graduate Medical Education (GME) program. These costs include the direct cost of salaries and benefits for interns, residents, and teachers. The amount of GME payment is from Worksheet E, Part A, line 11.

Total IP Reimbursement
The total amount of Medicare inpatient reimbursement for the cost reporting period is from Worksheet E, Part A, line 16 for PPS hospitals or from Worksheet E-3, Part I, line 17 or Worksheet E-3, Part II, Line 30 for non-PPS hospitals.

Total IP Costs
Total IP Costs corresponding to Total IP Reimbursement are calculated in the cost report and summarized on Worksheet D-1, Part II, line 49.

NPR Date
At the close of its fiscal year, a provider must submit a cost report to the FI showing the costs it incurred during the fiscal year and the proportion of those costs to be allocated to Medicare. The FI reviews the cost report, determines the total amount of Medicare reimbursement due the provider and issues the provider a Notice of Program Reimbursement (NPR). The NPR date is obtained from the most recent cost report data (HCRIS). There is no NPR date for cost reports as submitted or as amended by the provider (see Status above).

NPR Settlement Amount
The NPR Settlement Amount is the Balance due provider/(Program). It is the difference between the Total IP Reimbursement (above) and the total interim payments for the cost reporting period less any tentative settlements previously made by the FI. The Balance due provider/(Program) is from Worksheet E, Part A, line 29 for PPS hospitals or from Worksheet E-3, Part I, line 20 or Worksheet E-3, Part II, Line 33 for non-PPS hospitals.

NPR Settlement Percentage
This NPR settlement percentage is the NPR settlement amount as a percentage of total inpatient reimbursement. (It is calculated from the data elements previously defined.)

Date Generated
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ROPER HOSPITAL - CHARLESTON, SC
Cost report status - As Submitted
[Record code 7200 - 2010]

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 420087	PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET S PARTS I, II & III

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

FORM APPROVED OMB NO. 0938-0050

PART I - COST REPORT STATUS

Provider use only	1. [X] Electronically filed cost report		Date:	Time:
	2. [ ] Manually submitted cost report			
	3. [ ] 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. [1] Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended	6. Date Received: 05/30/2012	10. NPR Date:	
		7. Contractor No.: 11001	11. Contractor's Vendor Code: 4	
		8. [N] Initial Report for this Provider CCN	12. [ ] If line 5, column 1 is 4: Enter number of times reopened = 0-9.	
		9. [N] Final Report for this Provider CCN		

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 _____ {Provider Name(s) and Number(s)} for the cost reporting period beginning _____ and ending _____ and to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services identified in this cost report were provided in compliance with such laws and regulations.

	(Signed)	Name NOT AVAILIABLE ON ELECTRONIC FORM
		Officer or Administrator of Provider(s)
		Title NOT AVAILIABLE ON ELECTRONIC FORM
		Title
		_____
		Date

PART III - SETTLEMENT SUMMARY

		TITLE V	TITLE XVIII		HIT	TITLE XIX	
			PART A	PART B			
		1	2	3	4	5	
1	HOSPITAL		-807,982	-159,764		1,160,327	1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF		96,871				3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF						5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY						7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC						10
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER (Specify)						12
200	TOTAL		-711,111	-159,764		1,160,327	200

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 this 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 this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB 15-II, SECTIONS 4003.1-4003.3)

Rev. 2 | 40-503 - 08-11

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ROPER HOSPITAL - CHARLESTON, SC
Cost report status - As Submitted
[Record code 7200 - 2010]

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 420087	PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET S-10	
Uncompensated and indigent care cost computation				
1 Cost to charge ratio (Worksheet C, Part I line 200 column 3 divided by line 200 column 8)			0.267463	1
Medicaid (see instructions for each line)				
2 Net revenue from Medicaid			19,803,092	2
3 Did you receive DSH or supplemental payments from Medicaid?			Y	3
4 If line 3 is yes, does line 2 include all DSH or supplemental payments from Medicaid?			N	4
5 If line 4 is no, enter DSH or supplemental payments from Medicaid			2,326,693	5
6 Medicaid charges			84,436,912	6
7 Medicaid cost (line 1 times line 6)			22,583,750	7
8 Difference between net revenue and costs for Medicaid program (line 2 plus line 5 minus line 7)			453,965	8
State Children's Health Insurance Program (SCHIP) (see instructions for each line)				
9 Net revenue from stand-alone SCHIP				9
10 Stand-alone SCHIP charges				10
11 Stand-alone SCHIP cost (line 1 times line 10)				11
12 Difference between net revenue and costs for stand-alone SCHIP (line 9 minus line 11)				12
Other state or local government indigent care program (see instructions for each line)				
13 Net revenue from state or local indigent care program (not included on lines 2, 5 or 9)				13
14 Charges for patients covered under state or local indigent care program (not included in lines 6 or 10)				14
15 State or local indigent care program cost (line 1 times line 14)				15
16 Difference between net revenue and costs for state or local indigent care program (line 13 minus line 15)				16
Uncompensated care (see instructions for each line)				
17 Private grants, donations, or endowment income restricted to funding charity care				17
18 Government grants, appropriations or transfers for support of hospital operations				18
19 Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)			453,965	19
	Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
	1	2	3	
20 Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	44,058,724	8,499,013	52,557,736	20
21 Cost of initial obligation of patients approved for charity care (line 1 times line 20)	11,784,078	2,273,172	14,057,250	21
22 Partial payment by patients approved for charity care		523,164	523,164	22
23 Cost of charity care (line 21 minus line 22)	11,784,078	1,750,008	13,534,086	23
24 Does the amount in line 20, column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			N	24
25 If line 24 is yes, enter charges for patient days beyond an indigent care program's length of stay limit (see instructions)				25
26 Total bad debt expense for the entire hospital complex (see instructions)			32,415,836	26
27 Medicare bad debts for the entire hospital complex (see instructions)			555,365	27
28 Non-Medicare and non-reimbursable bad debt expense (line 26 minus line 27)			31,860,472	28
29 Cost of non-Medicare bad debt expense (line 1 times line 28)			8,521,497	29
30 Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)			22,055,584	30
31 Total unreimbursed and uncompensated care cost (line 19 plus line 30)			22,509,548	31

FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4012)

Rev. 2 | 40-523 - 08-11

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ROPER HOSPITAL - CHARLESTON, SC
Cost report status - As Submitted
[Record code 7200 - 2010]

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 420087	PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET S-2 PART 1

Hospital and Hospital Health Care Complex Address:

1	Street: 316 CALHOUN ST			P.O. Box:	1
2	City: CHARLESTON	State: SC	Zip Code: 29401	County: CHARLESTON	2

Hospital and Hospital-Based Component Identification:

	Component	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
	0	1	2	3	4	5	6	7	8	
3	Hospital	ROPER HOSPITAL	420087		1	10/01/1979	N	P	O	3
4	Subprovider- IPF									4
5	Subprovider- IRF	ROPER REHABILITATION HOSPITAL	42T087		5	10/01/1992	N	P	O	5
6	Subprovider- (Other)									6
7	Swing Beds-SNF						N	N	N	7
8	Swing Beds-NF						N		N	8
9	Hospital-Based SNF						N	N	N	9
10	Hospital-Based NF						N	N	N	10
11	Hospital-Based OLTC									11
12	Hospital-Based HHA	ROPER/ST. FRANCIS HOME HEALTH	427042			02/12/1988	N	P	O	12
13	Separately Certified ASC						N	N	N	13
14	Hospital-Based Hospice									14
15	Hospital-Based Health Clinic-RHC						N	N	N	15
16	Hospital-Based Health Clinic-FQHC						N	N	N	16
17	Hospital-Based (CMHC)						N	N	N	17
17.10							N	N	N	17.10
17.20							N	N	N	17.20
17.30							N	N	N	17.30
17.40							N	N	N	17.40
18	Renal Dialysis									18
19	Other									19

20	Cost Reporting Period (mm/dd/yyyy)	From: 01/01/2011	To: 12/31/2011			20
21	Type of control (see instructions)	2				21

Inpatient PPS Information		1	2	
22	Does this facility qualify for and receive disproportionate share hospital payment in accordance with 42 CFR §412.106, or low income payment in accordance with 42 CFR §412.624 (e)(2)? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR §412.06 (c)(2) (Pickle amendment hospital)? In column 2, enter "Y" for yes or "N" for no.	Y	N	22
23	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N	23

		In-State Medicaid paid days	In-State Medicaid eligible days	Out-of State Medicaid paid days	Out-of State Medicaid eligible days	Medicaid HMO days	Other Medicaid days	
		1	2	3	4	5	6	
24	If line 22 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.	3,310	453			3,058		24
25	If line 22 is "yes", and this provider is an IRF then, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible days in col. 2, out-of-state Medicaid 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.					841		25

26	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
27	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter "1" for urban or "2" for rural.	1	27

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 420087	PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET S-2 PART I	

35	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.				35
36	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:		36
37	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.				37
38	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:		38

		V	XVIII	XIX	
Prospective Payment System (PPS)-Capital		1	2	3	
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320? (see instructions)	N	Y	N	45
46	Is this facility eligible for the special exceptions payment pursuant to 42 CFR §412.348(g)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N	46
47	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47
48	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48

		1	2	3	
Teaching Hospitals					
56	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56
57	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.	N			57
58	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
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59
60	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)	Y			60
		Y/N	IME Average	Direct GME Average	
61	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)	N			61

ACA Provisions Affecting the Health Resources and Services Administration (HRSA)				
62	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)			62
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)			62.01

Teaching Hospitals that Claim Residents in Non-Provider Settings					
63	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
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.		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
64	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)				64

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1	2	3	4	5	
65	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)						65

Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings–Effective for cost reporting periods beginning on or after July 1, 2010	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
	1	2	3	
66 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)				66

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 420087	PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET S-2 PART I		

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1	2	3	4	5	
67	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)						67

Inpatient Psychiatric Facility PPS		1	2	3	
70	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70
71	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)					71
Inpatient Rehabilitation Facility PPS					
75	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes or "N" for no.	Y			75
76	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)	N			76
Long Term Care Hospital PPS					
80	Is this a Long Term Care Hospital (LTCH)? Enter "Y" for yes or "N" for no.	N			80
TEFRA Providers					
85	Is this a new hospital under 42 CFR §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N			85
86	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR §413.40(f)(1)(ii)? Enter "Y" for yes or "N" for no.	N			86

		V	XIX	
Title V and XIX Inpatient Services		1	2	
90	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in applicable column.	N	Y	90
91	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	Y	91
92	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
93	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
94	Does title V or title XIX reduce capital cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	94
95	If line 94 is "Y", enter the reduction percentage in the applicable column.			95
96	Does title V or title XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96
97	If line 96 is "Y", enter the reduction percentage in the applicable column.			97
Rural Providers		1	2	
105	Does this hospital qualify as a Critical Access Hospital (CAH)?	N		105
106	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106
107	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
108	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR §412.113(c). Enter "Y" for yes or "N" for no.	N		108

		Physical	Occupationa	Speech	Respiratory	
109	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	109
Miscellaneous Cost Reporting Information						
115	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
116	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116
117	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N				117
118	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
118.02		N				118.02
119	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.					119
120	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
121	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y				121
Transplant Center Information						
125	Does this facility operate a transplant center? Enter "Y" for yes or "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N				125

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 420087	PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET S-2 PART I

126	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126
127	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
128	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
129	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
130	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
131	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
132	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
133	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
134	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134

All Providers

		1	2	
140	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	42H055	140

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	Name: CAREALLIANCE HEALTH SERVICES		Contractor's Name: PALMETTO GBA		Contractor's Number:	141
142	Street: STREET: 315 CALHOUN ST. SUITE 107		P.O. Box:			142
143	City: CHARLESTON	State SC	Zip Code: 29401			143

144	Are provider based physicians' costs included in Worksheet A?	N	144
145	If costs for renal services are claimed on Worksheet A, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.	Y	145
146	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N	146
147	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N	147
148	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N	148
149	Was the change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N	149

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)	Part A	Part B	Title V	Title XIX	
	1	2	3	4	
155 Hospital	N	N	N	N	155
156 Subprovider - IPF	N	N	N	N	156
157 Subprovider - IRF	N	N	N	N	157
158 Subprovider - Other					158
159 SNF	N	N	N	N	159
160 HHA	N	N	N	N	160
161 CMHC		N		N	161
161.10		N		N	161.10
161.20		N		N	161.20
161.30		N		N	161.30
161.40		N		N	161.40

Multicampus

165	Is this hospital part of a multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N				165

If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip in column 3, CBSA in column 4, FTE/Campus in column 5.

	Name	County	State	Zip Code	CBSA	FTE/ Campus	
	0	1	2	3	4	5	
166							166

Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act

167	Is this provider a meaningful user under §1886 (n)? Enter "Y" for yes or "N" for no.	N		167
168	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)			168

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 420087	PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET S-2 PART I

169	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)		169

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ROPER HOSPITAL - CHARLESTON, SC
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08-11	FORM CMS-2552-10		4090 (Cont.)
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 420087	PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET S-2 Part II

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

		Y/N	Date		
Provider Organization and Operation		1	2		
1	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
		Y/N	Date	V/I	
		1	2	3	
2	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
3	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3
		Y/N	Type	Date	
Financial Data and Reports		1	2	3	
4	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4
5	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5

		Y/N	Y/N	
Approved Educational Activities		1	2	
6	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6
7	Are costs claimed for allied health programs? If yes, see instructions.	Y		7
8	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	Y		8
9	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N		9
10	Was an Intern-Resident program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10
11	Are GME costs directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11

		Y/N	
Bad Debts			
12	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12
13	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
14	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14
Bed Complement			
15	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15

		Part A		Part B		
		Y/N	Date	Y/N	Date	
PS&R Report Data		1	2	3	4	
16	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N		16
17	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	04/13/2012	Y	04/13/2012	17
18	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 the cost report? If yes, see instructions.	N		N		18
19	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		N		19
20	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N		20
21	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21

COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)

Capital Related Cost			
22	Have assets been relifed for Medicare purposes? If yes, see instructions.	N	22
23	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23
24	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions.	N	24
25	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N	25
26	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26
27	Has the provider's capitalization policy changed during the cost reporting period? If yes, see instructions.	N	27

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08-11	FORM CMS-2552-10	4090 (Cont.)	
Interest Expense			
28	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N	28
29	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
30	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30
31	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31
Purchased Services			
32	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N	32
33	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N	33
Provider-Based Physicians			
34	Are services furnished at the provider facility under an arrangement with provider-based physicians? If "Y" see instructions.	N	34
35	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
	Y/N	Date	
Home Office Costs	1	2	
36	Are home office costs claimed on the cost report?	N	36
37	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	N	37
38	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office	N	38
39	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N	39
40	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N	40
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40-510		Rev. 2	

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ROPER HOSPITAL - CHARLESTON, SC
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA									Provider CCN: 420087	PERIOD: FROM 01/01/2011 TO 12/31/2011		WORKSHEET S-3 PART I			
Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH Hours	Inpatient Days / Outpatient Visits / Trips				Full Time Equivalents			Discharges			
					Title V	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
1 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	278	101,470			32,728	2,364	59,686					7,023	836	14,255
2 HMO							3,511								
3 HMO IPF															
4 HMO IRF							841								
5 Hospital Adults & Peds. Swing Bed SNF															
6 Hospital Adults & Peds.Swing Bed NF															
7 Total Adults and Peds. (exclude observation beds) (see instructions)		278	101,470			32,728	2,364	59,686							
8 Intensive Care Unit		38	13,870			4,809	373	8,434							
9 Coronary Care Unit															
10 Burn Intensive Care Unit															
11 Surgical Intensive Care Unit															
12 Other Special Care															
13 Nursery	43.00						573	1,678							
14 Total (see instructions)		316	115,340			37,537	3,310	69,798		1,904.44			7,023	836	14,255
15 CAH visits															
16 Subprovider - IPF	40.00														
17 Subprovider - IRF	41.00	52	18,980			10,383		15,221		97.72			788		1,145
18 Subprovider - Other	42.00														
19 Skilled Nursing Facility	44.00														
20 Nursing Facility	45.00														
21 Other Long Term Care	46.00														
22 Home Health Agency	101.00					38,835	1,215	56,351		84.49					
23 ASC (Distinct Part)	115.00														
24 Hospice (Distinct Part)	116.00														
25 CMHC	99.00														
26 RHC/FQHC (specify)	88.00														
27 Total (sum of lines 14-26)		368								2,086.65					
28 Observation Bed Days								2,178							
28.															
29 Ambulance Trips						5,200									
30 Employee discount days (see instructions)															
31 Employee discount days -IRF															

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA		Provider CCN: 420087	PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET S-3 PART I	
32	Labor & delivery days (see instructions)				32
33	LTCH non-covered days				33
FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4005.1)					
Rev. 2					40-511 - 08-11

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ROPER HOSPITAL - CHARLESTON, SC
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HOSPITAL WAGE INDEX INFORMATION	Provider CCN: 420087	PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET S-3 PART II

Part II - Wage Data

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (column 2 ± column 3)	Paid Hours Related to Salaries in column 4	Average Hourly Wage (column 4 ÷ column 5)	
		1	2	3	4	5	6	
	SALARIES							
1	Total salaries (see instructions)	200	118,116,552	-1,580,052	116,536,496	4,392,979	** 26.53	1
2	Non-physician anesthetist Part A							2
3	Non-physician anesthetist Part B							3
4	Physician-Part A							4
5	Physician-Part B		1,521,505	-838,470	683,035	7,413	** 92.13	5
6	Non-physician-Part B							6
7	Interns & residents (in an approved program)	21						7
8	Home office personnel							8
9	SNF	44						9
10	Excluded area salaries (see instructions)		14,217,550	12,149	14,229,699	516,812	** 27.53	10
	OTHER WAGES AND RELATED COSTS							
11	Contract labor (see instructions)		913,154		913,154	23,275	** 39.23	11
12	Management and administrative services							12
13	Contract labor: physician-Part A		477,191		477,191	4,116	** 115.94	13
14	Home office salaries & wage-related costs		19,482,104		19,482,104	539,501	** 36.11	14
15	Home office: physician Part A							15
16	Teaching physician salaries (see instructions)							16
	WAGE-RELATED COSTS							
17	Wage-related costs (core) Worksheet S-3, Part IV line 24		20,223,692		20,223,692			17
18	Wage-related costs (other) Worksheet S-3, Part IV line 25							18
19	Excluded areas		2,811,193		2,811,193			19
20	Non-physician anesthetist Part A							20
21	Non-physician anesthetist Part B							21
22	Physician Part A							22
23	Physician Part B		300,004		300,004			23
24	Wage-related costs (RHC/FQHC)							24
25	Interns & residents (in an approved program)							25
	OVERHEAD COSTS - DIRECT SALARIES							
26	Employee Benefits	4	88	-88				26
27	Administrative & General	5	9,983,991	-939,292	9,044,699	394,775	** 22.91	27
28	Administrative & General under contract (see instructions)		5,551		5,551	303	** 18.32	28
29	Maintenance & Repairs	6						29
30	Operation of Plant	7	2,355,250		2,355,250	100,871	** 23.35	30
31	Laundry & Linen Service	8						31
32	Housekeeping	9	2,607,532		2,607,532	202,166	** 12.90	32
33	Housekeeping under contract (see instructions)							33
34	Dietary	10	58,413	-58,413				34
35	Dietary under contract (see instructions)		2,020,670		2,020,670	149,040	** 13.56	35
36	Cafeteria	11						36
37	Maintenance of Personnel	12						37
38	Nursing Administration	13	1,705,591	-497	1,705,094	49,893	** 34.18	38
39	Central Services and Supply	14						39
40	Pharmacy	15						40
41	Medical Records & Medical Records Library	16	1,828,425		1,828,425	99,197	** 18.43	41
42	Social Service	17						42
43	Other General Service	18						43

Part III - Hospital Wage Index Summary

1	Net salaries (see instructions)	118,621,264	-741,582	117,879,688	4,534,908	** 25.99	1
2	Excluded area salaries (see instructions)	14,217,550	12,149	14,229,699	516,812	** 27.53	2
3	Subtotal salaries (line 1 minus line 2)	104,403,720	-753,731	103,649,984	4,018,096	** 25.80	3

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HOSPITAL WAGE INDEX INFORMATION			Provider CCN: 420087		PERIOD: FROM 01/01/2011 TO 12/31/2011		WORKSHEET S-3 PART II	
4	Subtotal other wages and related costs (see instructions)		20,872,450		20,872,450	566,892	** 36.82	4
5	Subtotal wage-related costs (see instructions)		20,223,692		20,223,692			5
6	Total (sum of lines 3 through 5)				144,746,128			6
7	Total overhead cost (see instructions)		20,565,512	-998,290	19,567,220	996,245	** 19.64	7
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Rev. 2							40-513 - 08-11	

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HOSPITAL WAGE RELATED COSTS	Provider CCN: 420087	PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET S-3, PART IV

Part IV - Wage Related Cost

Part A - Core List

		Amount Reported	
RETIREMENT COST			
1	401k Employer Contributions		1
2	Tax Sheltered Annuity (TSA) Employer Contribution		2
3	Qualified and Non-Qualified Pension Plan Cost		3
4	Prior Year Pension Service Cost		4
PLAN ADMINISTRATIVE COSTS (Paid to External Organization):			
5	401k/TSA Plan Administration fees		5
6	Legal/Accounting/Management Fees-Pension Plan		6
7	Employee Managed Care Program Administration Fees		7
HEALTH AND INSURANCE COST			
8	Health Insurance (Purchased or Self Funded)	20,912,480	8
9	Prescription Drug Plan		9
10	Dental, Hearing and Vision Plan		10
11	Life Insurance (If employee is owner or beneficiary)		11
12	Accident Insurance (If employee is owner or beneficiary)		12
13	Disability Insurance (If employee is owner or beneficiary)		13
14	Long-Term Care Insurance (If employee is owner or beneficiary)		14
15	Workers' Compensation Insurance		15
16	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		16
TAXES			
17	FICA-Employers Portion Only	6,779,710	17
18	Medicare Taxes - Employers Portion Only		18
19	Unemployment Insurance		19
20	State or Federal Unemployment Taxes		20
OTHER			
21	Executive Deferred Compensation		21
22	Day Care Cost and Allowances		22
23	Tuition Reimbursement		23
24	Total Wage Related cost (Sum of lines 1 -23)	27,692,190	24

Part B - Other than Core Related Cost

25	Other Wage Related Costs (specify)_____		25

FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4005.4)

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ROPER HOSPITAL - CHARLESTON, SC
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HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provider CCN: 420087	PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET S-3, PART V

Part V - Contract Labor and Benefit Cost
Hospital and Hospital-Based Component Identification:

	Component	Contract Labor	Benefit Cost	
	0	1	2	
1	Total facility contract labor and benefit cost	3,416,566		1
2	Hospital	3,416,566		2
3	Subprovider- IPF			3
4	Subprovider- IRF			4
5	Subprovider- (Other)			5
6	Swing Beds-SNF			6
7	Swing Beds-NF			7
8	Hospital-Based SNF			8
9	Hospital-Based NF			9
10	Hospital-Based OLTC			10
11	Hospital-Based HHA			11
12	Separately Certified ASC			12
13	Hospital-Based Hospice			13
14	Hospital-Based Health Clinic RHC			14
15	Hospital-Based Health Clinic FQHC			15
16	Hospital-Based-CMHC			16
17	Renal Dialysis			17
18	Other			18

FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4005.5)

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ROPER HOSPITAL - CHARLESTON, SC
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HOSPITAL-BASED HOME HEALTH AGENCY STATISTICAL DATA	Provider CCN: 420087	PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET S-4

HOME HEALTH AGENCY STATISTICAL DATA — County:

	Description	Title V	Title XVIII	Title XIX	Other	Total	
		1	2	3	4	5	
1	Home Health Aide Hours		8,190	35	710	8,935	1
2	Unduplicated Census Count (see instructions)		1,923.00	73.00	1,196	3,192	2

HOME HEALTH AGENCY - NUMBER OF EMPLOYEES

Enter the number of hours in your normal work week ___40___

		Number of Employees (Full Time Equivalent)			
		Staff	Contract	Total	
		1	2	3	
3	Administrator and Assistant Administrator(s)				3
4	Director(s) and Assistant Director(s)	2.00		2.00	4
5	Other Administrative Personnel	25.08		25.08	5
6	Direct Nursing Service	17.92		17.92	6
7	Nursing Supervisor	3.00		3.00	7
8	Physical Therapy Service	20.64		20.64	8
9	Physical Therapy Supervisor	2.00		2.00	9
10	Occupational Therapy Service	5.68		5.68	10
11	Occupational Therapy Supervisor				11
12	Speech Pathology Service	1.860000		1.860000	12
13	Speech Pathology Supervisor				13
14	Medical Social Service	2.02		2.02	14
15	Medical Social Service Supervisor				15
16	Home Health Aide	4.30		4.30	16
17	Home Health Aide Supervisor				17
18	Other (specify)				18

HOME HEALTH AGENCY CBSA CODES

19	Enter the number of CBSAs where you provided services during the cost reporting period.	1.000000	19
20	List those CBSA code(s) serviced during this cost reporting period (line 20 contains the first code).		20

PPS ACTIVITY

		Full Episodes		LUPA Episodes	PEP only Episodes	Total (columns 1 through 4)	
		Without Outliers	With Outliers				
		1	2	3	4	5	
21	Skilled Nursing Visits	12,620.00	176.00	486.00	256	13,538	21
22	Skilled Nursing Visit Charges	1,641,010	22,880	63,180	32,630	1,759,700	22
23	Physical Therapy Visits	16,339.00	98.00	241.00	371	17,049	23
24	Physical Therapy Visit Charges	2,450,695	14,700	36,150	55,650	2,557,195	24
25	Occupational Therapy Visits	4,259.00	78.00	14.00	90	4,441	25
26	Occupational Therapy Visit Charges	638,830	11,700.00	2,100.00	13,500	666,130	26
27	Speech Pathology Visits	737.00	21.00	4.00	20	782	27
28	Speech Pathology Visit Charges	110,550	3,150	600.00	3,000	117,300	28
29	Medical Social Service Visits	154.00	2.00	4.00	8	168	29
30	Medical Social Service Visit Charges	23,100	300	600.00	900	24,900	30
31	Home Health Aide Visits	2,982.00	91.00	4.00	50	3,127	31
32	Home Health Aide Visit Charges	223,650	6,825	300.00	3,750	234,525	32
33	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	37,091	466 00	753.00	795	39,105	33
34	Other Charges						34
35	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	5,087,835	59,555	102,930	109,430	5,359,750	35
36	Total Number of Episodes (standard/non-outlier)	37,091.00		753.00	795	38,639	36
37	Total Number of Outlier Episodes		466 00			466	37
38	Total Non-Routine Medical Supply Charges	220,611		13,243.00	4,196	238,050	38

FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4006)

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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES			Provider CCN: 420087			PERIOD: FROM 01/01/2011 TO 12/31/2011		WORKSHEET A	
COST CENTER DESCRIPTIONS (omit cents)			SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	RECLASSIFIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	Capital Related Costs-Buildings and Fixtures		20,457,728	20,457,728	-9,271,530	11,186,198	10,253,235	21,439,432	1
2	00200	Capital Related Costs-Movable Equipment		488,743	488,743	9,271,530	9,760,273	5,308,042	15,068,315	2
3	00300	Other Capital Related Costs							-0-	3
4	00400	Employee Benefits	88	27,688,652	27,688,740	304,378	27,993,116	-1,748,442	26,244,676	4
5	00500	Administrative and General								5
5.05		Other Administrative & General	9,983,991	58,123,836	68,107,825	-11,873	68,095,953	-12,046,529	56,049,425	5.05
6	00600	Maintenance and Repairs								6
7	00700	Operation of Plant	2,355,250	12,460,989	14,816,239		14,816,239	-93,038	14,723,201	7
8	00800	Laundry and Linen Service		1,332,905	1,332,905		1,332,905		1,332,905	8
9	00900	Housekeeping	2,607,532	533,282	3,140,814		3,140,814		3,140,814	9
10	01000	Dietary	58,413	5,759,437	5,817,850	-276	5,817,574		5,817,574	10
11	01100	Cafeteria						-1,803,981	-1,803,981	11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	1,705,591	119,689	1,825,280		1,825,280	-13,053	1,812,227	13
14	01400	Central Services and Supply								14
15	01500	Pharmacy								15
16	01600	Medical Records & Medical Records Library	1,828,425	253,056	2,081,481		2,081,481	-1,078	2,080,403	16
17	01700	Social Service								17
18		Other General Service (specify)								18
19	01900	Nonphysician Anesthetists								19
20	02000	Nursing School								20
21	02100	Intern & Res. Service-Salary & Fringes (Approved)								21
22	02200	Intern & Res. Other Program Costs (Approved)								22
23	02300	Paramedical Ed. Program (specify)	123,389	6,272	129,661	12,149	141,810	-1,400	140,410	23
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults and Pediatrics (General Routine Care)	26,930,570	2,420,730	29,351,300	-1,167,222	28,184,078		28,184,078	30
31	03100	Intensive Care Unit	6,180,552	1,117,218	7,297,770		7,297,770		7,297,770	31
32	03200	Coronary Care Unit								32
33	03300	Burn Intensive Care Unit								33
34	03400	Surgical Intensive Care Unit								34
35		Other Special Care (specify)								35
40	04000	Subprovider - IPF								40
41	04100	Subprovider - IRF	5,192,735	548,134	5,740,869		5,740,869	-5,135	5,735,734	41

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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES					Provider CCN: 420087		PERIOD FROM 01/01/2011 TO 12/31/2011		WORKSHEET A	
COST CENTER DESCRIPTIONS (omit cents)			SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	RECLASSIFIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
42	04200	Subprovider (specify)								42
43	04300	Nursery	866,837	143,007	1,009,844		1,009,844		1,009,844	43
44	04400	Skilled Nursing Facility								44
45	04500	Nursing Facility								45
46	04600	Other Long Term Care								46
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	9,749,355	17,852,624	27,601,978		27,601,978	-3,019,819	24,582,160	50
51	05100	Recovery Room	1,769,741	213,475	1,983,216		1,983,216		1,983,216	51
52	05200	Labor Room and Delivery Room				1,167,222	1,167,222		1,167,222	52
53	05300	Anesthesiology								53
54	05400	Radiology-Diagnostic	6,553,069	4,994,867	11,547,936		11,547,936	-708,518	10,839,418	54
55	05500	Radiology-Therapeutic	3,401,142	1,573,412	4,974,554		4,974,554		4,974,554	55
56	05600	Radioisotope								56
57	05700	Computed Tomography (CT) Scan	512,551	343,376	855,927		855,927	-4,639	851,288	57
58	05800	Magnetic Resonance Imaging (MRI)	285,610	138,878	424,488		424,488		424,488	58
59	05900	Cardiac Catheterization	2,396,772	1,168,559	3,565,331		3,565,331	-81,731	3,483,600	59
60	06000	Laboratory	5,447,330	5,173,957	10,621,287		10,621,287	-1,380,731	9,240,556	60
60.45	06000	Vascular Lab	954,422	505,937	1,460,359		1,460,359	-136,208	1,324,151	60.45
61	06100	PBP Clinical Laboratory Services-Program Only								61
62	06200	Whole Blood & Packed Red Blood Cells								62
63	06300	Blood Storing, Processing, & Trans.	342,023	2,859,804	3,201,827		3,201,827	-4,968	3,196,859	63
64	06400	Intravenous Therapy								64
65	06500	Respiratory Therapy	2,251,006	515,165	2,766,171		2,766,171	-23,775	2,742,396	65
66	06600	Physical Therapy	3,723,950	76,195	3,800,145		3,800,145		3,800,145	66
67	06700	Occupational Therapy								67
68	06800	Speech Pathology								68
69	06900	Electrocardiology	642,386	32,045	674,431		674,431		674,431	69
70	07000	Electroencephalography								70
71	07100	Medical Supplies Charged to Patients								71
72	07200	Implantable Devices Charged to Patients		25,066,800	25,066,800		25,066,800		25,066,800	72
73	07300	Drugs Charged to Patients	5,309,154	16,084,132	21,393,286		21,393,286	-2,222	21,391,064	73
74	07400	Renal Dialysis								74
75	07500	ASC (Non-Distinct Part)								75
76		Other Ancillary (specify)								76
76.30		Other Ancillary Cost Centers	834,909	498,859	1,333,768		1,333,768	-12,665	1,321,103	76.30
		OUTPATIENT SERVICE COST CENTERS								
88	08800	Rural Health Clinic (RHC)								88

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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES			Provider CCN: 420087			PERIOD: FROM 01/01/2011 TO 12/31/2011		WORKSHEET A	
		COST CENTER DESCRIPTIONS (omit cents)	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	RECLASSIFIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
89	08900	Federally Qualified Health Center (FQHC)								89
90	09000	Clinic								90
91	09100	Emergency	7,208,332	10,801,841	18,010,172		18,010,172	-9,886,088	8,124,085	91
92	09200	Observation Beds								92
93		Other Outpatient Service (specify)								93
		OTHER REIMBURSABLE COST CENTERS								
94	09400	Home Program Dialysis								94
95	09500	Ambulance Services	1,660,939	300,536	1,961,475		1,961,475		1,961,475	95
96	09600	Durable Medical Equipment-Rented								96
97	09700	Durable Medical Equipment-Sold								97
98		Other Reimbursable (specify)								98
99		Outpatient Rehabilitation Provider (specify)								99
100	10000	Intern-Resident Service (not apprvd. tchng prgm.)								100
101	10100	Home Health Agency	5,799,100	935,283	6,734,383	-304,378	6,430,005		6,430,005	101
		SPECIAL PURPOSE COST CENTERS								
105	10500	Kidney Acquisition								105
106	10600	Heart Acquisition								106
107	10700	Liver Acquisition								107
108	10800	Lung Acquisition								108
109	10900	Pancreas Acquisition								109
110	11000	Intestinal Acquisition								110
111	11100	Islet Acquisition								111
112		Other Organ Acquisition (specify)								112
113	11300	Interest Expense							- 0 -	113
114	11400	Utilization Review-SNF							- 0 -	114
115	11500	Ambulatory Surgical Center (Distinct Part)								115
116	11600	Hospice								116
117		Other Special Purpose (specify)								117
118		SUBTOTALS (sum of lines 1-117)	116,675,168	220,589,424	337,264,576		337,264,576	-15,412,743	321,851,840	118
		NONREIMBURSABLE COST CENTERS								
190	19000	Gift, Flower, Coffee Shop, & Canteen	130,769	246,660	377,429		377,429	-377,429		190
191	19100	Research								191
192	19200	Physicians' Private Offices								192
193	19300	Nonpaid Workers								193
194		Other Nonreimbursable (specify)	1,310,618	2,510,402	3,821,020		3,821,020	-2,800,501	1,020,519	194
200		TOTAL (sum of lines 118-199)	118,116,552	223,346,480	341,463,040	- 0 -	341,463,040	-18,590,672	322,872,352	200

FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB 15-II, SECTION 4013)

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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES			Provider CCN: 420087		PERIOD: FROM 01/01/2011 TO 12/31/2011		WORKSHEET A
COST CENTER DESCRIPTIONS (omit cents)	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	RECLASSIFIED TRIAL BALANCE (col 3 ± col. 4)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 5 ± col. 6)
	1	2	3	4	5	6	7
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RECLASSIFICATIONS	Provider CCN: 420087	PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET A-6

E - VASCULAR SERVIECS SALARY

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	INCREASES				DECREASES				Wkst. A-7 Ref.	
			COST CENTER	LINE #	SALARY	OTHER	COST CENTER	LINE #	SALARY	OTHER		
		1	2	3	4	5	6	7	8	9	10	
1	VASCULAR SERVIECS SALARY	E		76.01		102,138		76.01	102,138			1
2												2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21												21
22												22
23												23
24												24
25												25
26												26
27												27
28												28
29												29
500	Total reclassifications (sum of columns 4 and 5 must equal sum of columns 8 and 9)					102,138			102,138			500

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.

Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate

FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB 15-II, SECTION 4014)

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RECLASSIFICATIONS	Provider CCN: 420087	PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET A-6

H - CPE RECLASS

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	INCREASES				DECREASES				Wkst. A-7 Ref	
			COST CENTER	LINE #	SALARY	OTHER	COST CENTER	LINE #	SALARY	OTHER		
		1	2	3	4	5	6	7	8	9	10	
1	CPE RECLASS	H		23.00	12,149			5.01	12,149			1
2												2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21												21
22												22
23												23
24												24
25												25
26												26
27												27
28												28
29												29
500	Total reclassifications (sum of columns 4 and 5 must equal sum of columns 8 and 9)				12,149				12,149			500

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.

Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate

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RECLASSIFICATIONS	Provider CCN. 420087	PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET A-6

F - DIETARY RECLASS

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	INCREASES				DECREASES				Wkst. A-7 Ref.	
			COST CENTER	LINE #	SALARY	OTHER	COST CENTER	LINE #	SALARY	OTHER		
		1	2	3	4	5	6	7	8	9	10	
1	DIETARY RECLASS	F		10.00		58,137		10.00	58,137			1
2	DIETARY RECLASS	F		5.01	276			10.00	276			2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21												21
22												22
23												23
24												24
25												25
26												26
27												27
28												28
29												29
500	Total reclassifications (sum of columns 4 and 5 must equal sum of columns 8 and 9)				276	58,137			58,413			500

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.

Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate

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RECLASSIFICATIONS	Provider CCN: 420087	PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET A-6

C - HOME HEALTH FICA

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	INCREASES				DECREASES				Wkst. A-7 Ref.	
			COST CENTER	LINE #	SALARY	OTHER	COST CENTER	LINE #	SALARY	OTHER		
		1	2	3	4	5	6	7	8	9	10	
1	HOME HEALTH FICA	C		4.00		304,378		101.00		304,378		1
2												2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21												21
22												22
23												23
24												24
25												25
26												26
27												27
28												28
29												29
500	Total reclassifications (sum of columns 4 and 5 must equal sum of columns 8 and 9)					304,378				304,378		500

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.

Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate

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RECLASSIFICATIONS	Provider CCN: 420087	PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET A-6

D - EMPLOYEE BENEIFT W-2 EXPEN

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	INCREASES				DECREASES				Wkst. A-7 Ref.	
			COST CENTER	LINE #	SALARY	OTHER	COST CENTER	LINE #	SALARY	OTHER		
		1	2	3	4	5	6	7	8	9	10	
1	EMPLOYEE BENEIFT W-2 EXPENSE	D		4.00		88		4.00	88			1
2												2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21												21
22												22
23												23
24												24
25												25
26												26
27												27
28												28
29												29
500	Total reclassifications (sum of columns 4 and 5 must equal sum of columns 8 and 9)					88			88			500

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.

Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.

FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB 15-II, SECTION 4014)

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RECLASSIFICATIONS	Provider CCN: 420087	PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET A-6

A - RECLASS DEPRECIATION EXPEN

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	INCREASES				DECREASES				Wkst. A-7 Ref.	
			COST CENTER	LINE #	SALARY	OTHER	COST CENTER	LINE #	SALARY	OTHER		
		1	2	3	4	5	6	7	8	9	10	
1	RECLASS DEPRECIATION EXPENS	A		2.00		9,271,530		1.00		9,271,530	9	1
2												2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
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21												21
22												22
23												23
24												24
25												25
26												26
27												27
28												28
29												29
500	Total reclassifications (sum of columns 4 and 5 must equal sum of columns 8 and 9)					9,271,530				9,271,530		500

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.

Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.

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RECLASSIFICATIONS							Provider CCN 420087	PERIOD: FROM 01/01/2011 TO 12/31/2011		WORKSHEET A-6		
B - LABOR AND DELIVERY RECLASS												
EXPLANATION OF RECLASSIFICATION(S)		CODE (1)	INCREASES				DECREASES				Wkst. A-7 Ref.	
			COST CENTER	LINE #	SALARY	OTHER	COST CENTER	LINE #	SALARY	OTHER		
		1	2	3	4	5	6	7	8	9	10	
1	LABOR AND DELIVERY RECLASS	B		52.00	1,013,432	153,790		30.00	1,013,432	153,790		1
2												2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21												21
22												22
23												23
24												24
25												25
26												26
27												27
28												28
29												29
500	Total reclassifications (sum of columns 4 and 5 must equal sum of columns 8 and 9)				1,013,432	153,790			1,013,432	153,790		500

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.

Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.

FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4014)

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RECLASSIFICATIONS	Provider CCN: 420087	PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET A-6

G - PROF FEES PART B RECLASS

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	INCREASES				DECREASES				Wkst. A-7 Ref.	
			COST CENTER	LINE #	SALARY	OTHER	COST CENTER	LINE #	SALARY	OTHER		
		1	2	3	4	5	6	7	8	9	10	
1	PROF FEES PART B RECLASS	G		5.01		927,419		5.01	927,419			1
2	PROF FEES PART B RECLASS	G		13.00		497		13.00	497			2
3	PROF FEES PART B RECLASS	G		59.00		1,200		59.00	1,200			3
4	PROF FEES PART B RECLASS	G		91.00		490,573		91.00	490,573			4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21												21
22												22
23												23
24												24
25												25
26												26
27												27
28												28
29												29
500	Total reclassifications (sum of columns 4 and 5 must equal sum of columns 8 and 9)					1,419,689			1,419,689			500

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.

Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.

FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4014)

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ROPER HOSPITAL - CHARLESTON, SC
Cost report status - As Submitted
[Record code 7200 - 2010]

RECONCILIATION OF CAPITAL COSTS CENTERS	Provider CCN: 420087	PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET A-7, PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES

	Description	Beginning Balances	Acquisitions			Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
			Purchases	Donation	Total				
		1	2	3	4	5	6	7	
1	Land	3,872,178					3,872,178		1
2	Land Improvements	2,600,031	49,645		49,645		2,649,676		2
3	Buildings and Fixtures	126,244,440	61,498		61,498	54,575	126,251,368		3
4	Building Improvements	98,846,552	12,332,919		12,332,919	5,599	111,173,872		4
5	Fixed Equipment	1,780,252	184,413		184,413	2,239	1,962,426		5
6	Movable Equipment	96,865,736	7,326,073		7,326,073	5,110,887	99,080,920		6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	330,209,184	19,954,548		19,954,548	5,173,300	344,990,432		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	330,209,184	19,954,548		19,954,548	5,173,300	344,990,432		10

PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 AND 2

	Description	SUMMARY OF CAPITAL							
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		9	10	11	12	13	14	15	
1	Capital Related Costs-Buildings and Fixtures	18,061,388	2,396,340					20,457,728	1
2	Capital Related Costs-Movable Equipment		488,743					488,743	2
3	Total (sum of lines 1-2)	18,061,388	2,885,083					20,946,472	3

(1) The amount in columns 9 through 14 must equal the amount on Worksheet A, column 2, lines 1 and 2. Enter in each column the appropriate amounts including any directly assigned cost that may have been included in Worksheet A, column 2, lines 1 and 2. All lines numbers are to be consistent with Worksheet A line numbers for capital cost centers.

PART III - RECONCILIATION OF CAPITAL COSTS CENTERS

	Description	COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	
		1	2	3	4	5	6	7	8	
1	Capital Related Costs-Buildings and Fixtures	243,947,088		243,947,088						1
2	Capital Related Costs-Movable Equipment	101,043,344		101,043,344						2
3	Total (sum of lines 1-2)	344,990,432		344,990,432	1.000000					3

	Description	SUMMARY OF CAPITAL							
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		9	10	11	12	13	14	15	
1	Capital Related Costs-Buildings and Fixtures	19,544,212	1,895,220					21,439,432	1
2	Capital Related Costs-Movable Equipment	14,579,572	488,743					15,068,315	2
3	Total (sum of lines 1-2)	34,123,784	2,383,963					36,507,748	3

(2) The amounts on lines 1 and 2 must equal the corresponding amounts on Worksheet A, column 7, lines 1 and 2. Columns 9 through 14 should include related Worksheet A-6 reclassifications, Worksheet A-8 adjustments, and Worksheet A-8-1 related organizations and home office costs. (See instructions.)

FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTIONS 4015)

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ADJUSTMENTS TO EXPENSES		Provider CCN: 420087		PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET A-8		
DESCRIPTION (1)		BASIS/CODE (2)	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		Wkst. A-7 Ref.	
				COST CENTER	LINE #		
		1	2	3	4	5	
1	Investment income - buildings and fixtures (chapter 2)			Buildings and Fixtures	1		1
2	Investment income - movable equipment (chapter 2)			Movable Equipment	2		2
3	Investment income - other (chapter 2)						3
4	Trade, quantity, and time discounts (chapter 8)						4
5	Refunds and rebates of expenses (chapter 8)						5
6	Rental of provider space by suppliers (chapter 8)						6
7	Telephone services (pay stations excluded) (chapter 21)						7
8	Television and radio service (chapter 21)						8
9	Parking lot (chapter 21)						9
10	Provider-based physician adjustment	Worksheet A-8-2					10
11	Sale of scrap, waste, etc. (chapter 23)						11
12	Related organization transactions (chapter 10)	Worksheet A-8-1	4,679,949				12
13	Laundry and linen service						13
14	Cafeteria-employees and guests						14
15	Rental of quarters to employee and others						15
16	Sale of medical and surgical supplies to other than patients						16
17	Sale of drugs to other than patients						17
18	Sale of medical records and abstracts						18
19	Nursing school (tuition, fees, books, etc.)						19
20	Vending machines						20
21	Income from imposition of interest, finance or penalty charges (chapter 21)						21
22	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments						22
23	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	Worksheet A-8-3		Respiratory Therapy	65		23
24	Adjustment for physical therapy costs in excess of limitation (chapter 14)	Worksheet A-8-3		Physical Therapy	66		24
25	Utilization review - physicians' compensation (chapter 21)			Utilization Review - SNF	114		25
26	Depreciation - buildings and fixtures			Buildings and Fixtures	1		26
27	Depreciation - movable equipment			Movable Equipment	2		27
28	Non-physician Anesthetist			Nonphysician Anesthetist	19		28
29	Physicians' assistant						29
30	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	Worksheet A-8-3		Occupational Therapy	67		30
31	Adjustment for speech pathology costs in excess of limitation (chapter 14)	Worksheet A-8-3		Speech Pathology	68		31
32	CAH HIT Adjustment for Depreciation and Interest						32
33	Other adjustments (specify) (3)						33
33.00	MISC INCOME - GIFT SHOP	B	-377,429	GIFT FLOWER COFFEE SHOP & CANTEEN	190.00		33.00
33.01	MISC INCOME - A & G	B	-202,611	RH ADMIN & GENERAL	5.01		33.01
33.02	MISC INCOME - GARAGE REVENUE	B	-93,038	OPERATION OF PLANT	7.00		33.02
33.03	MISC INCOME - CAFETERIA MEALS	B	-1,803,981	CAFETERIA	11.00		33.03
33.04	MISC INCOME - MED RECORD TRANS	B	-1,078	MEDICAL RECORDS & LIBRARY	16.00		33.04
33.05	MISC INCOME - CPE	B	-1,400	PARAMED ED PRGM-(CPE)	23.00		33.05
33.06	MISC INCOME - RADIOLOGY	B	-28,189	RADIOLOGY-DIAGNOSTIC	54.00		33.06

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ADJUSTMENTS TO EXPENSES		Provider CCN: 420087		PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET A-8		
33.07	MISC INCOME - CT SCAN	B	-12,250	COMPUTED TOMOGRAPHY (CT) SCAN	57.00		33.07
33.08	MISC INCOME - CARDIAC CATH	B	-80,261	CARDIAC CATHETERIZATION	59.00		33.08
33.09	MISC INCOME - LAB	B	-218,771	LABORATORY	60.00		33.09
33.10	MISC INCOME - RT SLEEP STUDIES	B	-23,775	RESPIRATORY THERAPY	65.00		33.10
33.11	MISC INCOME - VASCULAR SERVICES	B	-27,542	VASCULAR SERVICES	76.01		33.11
33.12	MISC INCOME - DRUGS	B	-2,000	DRUGS CHARGED TO PATIENTS	73.00		33.12
33.13	MISC INCOME - COMMUNITY PROGRAM	B	-1,764,445	OTHER NON-REIMBURSABLE SERVICES	194.02		33.13
34.00	PHYS RECRUITMENT	A	-58,229	OTHER NON-REIMBURSABLE SERVICES	194.02		34.00
35.00	LUCAS HOUSE DEPRECIATION	A	-4,241	CAP REL COSTS-BLDG & FIXT	1.00	9	35.00
36.00	CAPTIAL CARRY FORWARD	A	62,456	CAP REL COSTS-BLDG & FIXT	1.00	9	36.00
37.00	PROF FEE EXPENSE - BENEFIT EXPE	A	-182,665	EMPLOYEE BENEFITS	4.00		37.00
37.01	PROF FEE EXPENSE - BILLING SOFT	A	-2,400	SUBPROVIDER - IRF	41.00		37.01
37.02	PROF FEE EXPENSE - INTENSIVISTS	A	-1,768,136	RH ADMIN & GENERAL	5.01		37.02
37.03	PROF FEE EXPENSE - ANESTHESIA	A	-3,004,755	OPERATING ROOM	50.00		37.03
37.04	PROF FEE EXPENSE - PHYSICIAN SV	A	-891,819	EMERGENCY	91.00		37.04
37.05	PROF FEE EXPENSE - BILLING SOFT	A	-2,400	OTHER NON-REIMBURSABLE SERVICES	194.02		37.05
37.06	PROF FEE EXPENSE - BILLING SOFT	A	-240	OTHER NON-REIMBURSABLE SERVICES	194.02		37.06
38.00	PROF FEES/SALARY - EMPLOYEE BE	A	-118,012	EMPLOYEE BENEFITS	4.00		38.00
38.01	PROF. FEES/SALARY - INTENSIVIST	A	-176,770	RH ADMIN & GENERAL	5.01		38.01
38.02	PROF FEES/SALARY - NURSING ADMI	A	-497	NURSING ADMINISTRATION	13.00		38.02
38.03	PROF FEES/SALARY - RADIOLOGY	A	-636,301	RADIOLOGY-DIAGNOSTIC	54.00		38.03
38.04	PROF FEES/SALARY - CT SCAN	A	7,611	COMPUTED TOMOGRAPHY (CT) SCAN	57.00		38.04
38.05	PROF FEES/SALARY - LAB	A	-717,376	LABORATORY	60.00		38.05
38.06	PROF FEES/SALARY - CATH LAB	A	-1,200	CARDIAC CATHETERIZATION	59.00		38.06
38.07	PROF FEES/SALARY - VASCULAR SER	A	-108,666	VASCULAR SERVICES	76.01		38.07
38.08	PROF FEES/SALARY - ER	A	-8,994,269	EMERGENCY	91.00		38.08
38.09	PROF FEES/SALARY - COMMUNITY PR	A	-975,187	OTHER NON-REIMBURSABLE SERVICES	194.02		38.09
39.00	STAR CONTRACT REV - OPERATING R	B	-15,064	OPERATING ROOM	50.00		39.00
39.01	STAR CONTRACT REV - RADIOLOGY D	B	-44,028	RADIOLOGY-DIAGNOSTIC	54.00		39.01
39.03	STAR CONTRACT REV - LAB	B	-444,584	LABORATORY	60.00		39.03
39.04	STAR CONTRACT REV - BLOOD STORI	B	-4,968	BLOOD STORING PROCESSING & TRANS.	63.00		39.04
39.06	STAR CONTRACT REV - ELECTROCARD	B	-222	DRUGS CHARGED TO PATIENTS	73.00		39.06
40.00	PATIENT TELEPHONE EXPENSE	A	-10,632	RH ADMIN & GENERAL	5.01		40.00
43.00	LOBBYING - REHAB	A	-2,735	SUBPROVIDER - IRF	41.00		43.00
44.00	COLEMAN BLVD OTHER EXPENSE	A	-1,140	RH ADMIN & GENERAL	5.01		44.00
44.01	RENT EXPENSE NRTPC	A	-427,082	CAP REL COSTS-BLDG & FIXT	1.00	10	44.01
45.00	NRTPC - CASE MGMT DONATIONS O	A	-97,475	RH ADMIN & GENERAL	5.01	10	45.00
45.01	MISC NRTPC - RESEARCH	A	-12,556	NURSING ADMINISTRATION	13.00		45.01
45.02	MISC NRTPC - RESEARCH	A	-270	CARDIAC CATHETERIZATION	59.00		45.02
50	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200)		-18,590,672				50

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1

(2) Basis for adjustment (see instructions)
A. Costs - if cost, including applicable overhead, can be determined
B. Amount Received - if cost cannot be determined

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to Worksheet A-7.

FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4016)

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ROPER HOSPITAL - CHARLESTON, SC
Cost report status - As Submitted
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STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 420087	PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET A-8-1

A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount included in Wkst. A column 5	Net Adjustments (col. 4 minus col. 5) *	Wkst. A-7 Ref.	
	1	2	3	4	5	6	7	
1	4.00	EMPLOYEE BENEFITS	CONTRA EMPLOYEE BENEFITS	19,464,716	20,912,480	-1,447,765		1
2	5.01	RH ADMIN & GENERAL	CORPORATE ALLOCATION	17,613,534	43,671,488	-26,057,956		2
3	5.01	RH ADMIN & GENERAL	HO SALARIES	16,268,191		16,268,191		3
4	1.00	CAP REL COSTS-BLDG & FIXT	CRC - BLDG & FIX NEW	10,696,140		10,696,140	9	4
4.01	2.00	CAP REL COSTS-MVBLE EQUIP	CRC - MME NEW	90,122		90,122	9	4.01
4.02	2.00	CAP REL COSTS-MVBLE EQUIP	SHARED CRC MME	5,217,920		5,217,920	9	4.02
4.03	60.00	LABORATORY	PURCHASED SVC OTHER	-376,539	-376,539			4.03
4.04	76.03	PURCHASED CLINICAL SERVICES	PURCHASED SERVICES OTHER	5,126	17,791	-12,665		4.04
4.05	1.00	CAP REL COSTS-BLDG & FIXT	RLTD PARTY RENT EXPENSE		66,285	-66,285	10	4.05
4.06	1.00	CAP REL COSTS-BLDG & FIXT	RLTD PARTY RENT EXPENSE		7,753	-7,753	10	4.06
4.08	5.01	RH ADMIN & GENERAL	CONTRA SUPPORT FROM FOUND	-60,012	-60,012			4.08
4.09	41.00	SUBPROVIDER - IRF	CONTRA SUPPORT FROM FOUND	-67,117	-67,117			4.09
4.10	43.00	NURSERY	CONTRA SUPPORT FROM FOUND	-1,529	-1,529			4.10
4.11	50.00	OPERATING ROOM	CONTRA SUPPORT FROM FOUND	-5,000	-5,000			4.11
4.12	54.00	RADIOLOGY-DIAGNOSTIC	CONTRA SUPPORT FROM FOUND	-16,859	-16,859			4.12
4.13	55.00	RADIOLOGY-THERAPEUTIC	CONTRA SUPPORT FROM FOUND	-73,146	-73,146			4.13
4.14	59.00	CARDIAC CATHETERIZATION	CONTRA SUPPORT FROM FOUND	-7,500	-7,500			4.14
4.15	60.00	LABORATORY	CONTRA SUPPORT FROM FOUND	-2,982	-2,982			4.15
4.16	76.01	VASCULAR SERVICES	CONTRA SUPPORT FROM FOUND	-5,779	-5,779			4.16
4.17	91.00	EMERGENCY	CONTRA SUPPORT FROM FOUND	-10,159	-10,159			4.17
4.18	101.00	HOME HEALTH AGENCY	CONTRA SUPPORT FROM FOUND	-579	-579			4.18
4.19	194.02	OTHER NON-REIMBURSABLE SERVICES	CONTRA SUPPORT FROM FOUND	-2,212,492	-2,212,492			4.19
5	TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			66,516,056	61,836,104	4,679,949		5

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

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

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.

B. Corporation, partnership, or other organization has financial interest in provider.

C. Provider has financial interest in corporation, partnership, or other organization.

D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.

E. Individual is director, officer, administrator, or key person of provider and related organization.

F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

G. Other (financial or non-financial) specify _____

FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4017)

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STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 420087	PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET A-8-1

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

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

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

	Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office			
				Name	Percentage of Ownership	Type of Business	
	1	2	3	4	5	6	
6	B			CAREALLIANCE HEALTH SERVICES		HOME OFFICE	6
7	G			ST FRANCIS XAVIER HOSPITAL		SHARED SERVICES	7
8	G			MT. PLEASANT HOSPITAL		SHARED SERVICES	8
9	G			ROPER FOUNDATION		FUND RAISING	9
10							10

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

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

FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4017)

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COST ALLOCATION - GENERAL SERVICE COSTS				Provider CCN: 420087		PERIOD FROM 01/01/2011 TO 12/31/2011						WORKSHEET B, PART I	
	COST CENTER DESCRIPTIONS	NET EXPENSES FOR COST ALLOCATION (from Wkst. A col. 7)	CAPITAL RELATED COSTS BLDGS. & FIXTURES	CAPITAL RELATED COSTS MOVABLE EQUIPMENT	EMPLOYEE BENEFITS	SUBTOTAL (cols. 0-4)	ADMINIS-TRATIVE & GENERAL	MAIN-TENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	
		0	1	2	4	4A	5	6	7	8	9	10	11	
	GENERAL SERVICE COST CENTERS													
1	Capital Related Costs-Buildings and Fixtures	21,439,432	21,439,432											1
2	Capital Related Costs-Movable Equipment	15,068,315		15,068,315										2
4	Employee Benefits	26,244,676	101,465		26,346,140									4
5	Administrative and General													5
5.05	Other Administrative & General	56,049,425	1,870,772	156,807	2,044,790	60,121,793	60,564,939							5.05
6	Maintenance and Repairs													6
7	Operation of Plant	14,723,201	4,460,492	692,954	532,465	20,409,112	4,544,252		24,953,364					7
8	Laundry and Linen Service	1,332,905	57,932	263		1,391,100	309,740		96,331	1,797,171				8
9	Housekeeping	3,140,814	534,789	26,691	589,500	4,291,794	955,602		889,255		6,136,651			9
10	Dietary	5,817,574	472,957	89,080		6,379,611	1,420,471		786,440		201,358	8,787,880		10
11	Cafeteria	-1,803,981				-1,803,981						2,966,013	1,162,032	11
12	Maintenance of Personnel													12
13	Nursing Administration	1,812,227	105,058		385,481	2,302,766	512,729		174,692		44,728		19,299	13
14	Central Services and Supply													14
15	Pharmacy													15
16	Medical Records & Medical Records Library	2,080,403	197,332	8,685	413,363	2,699,783	601,128		328,127		84,013		38,364	16
17	Social Service													17
18	Other General Service (specify)													18
19	Nonphysician Anesthetists													19
20	Nursing School													20
21	Intern & Res. Service-Salary & Fringes (Approved)													21
22	Intern & Res. Other Program Costs (Approved)													22
23	Paramedical Education Program (specify)	140,410	26,042	44	30,642	197,138	43,894		43,303		11,087		3,668	23
	INPATIENT ROUTINE SERVICE COST CENTERS													
30	Adults and Pediatrics (General Routine Care)	28,184,078	5,016,256	858,967	5,859,277	39,918,576	8,888,101		8,341,101	890,812	2,135,634	2,669,912	378,179	30
31	Intensive Care Unit	7,297,770	901,100	394,579	1,397,274	9,990,723	2,224,514		1,498,362	155,290	383,637	240,516	78,538	31
32	Coronary Care Unit													32
33	Burn Intensive Care Unit													33
34	Surgical Intensive Care Unit													34
35	Other Special Care Unit (specify)													35
40	Subprovider IPF													40

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COST ALLOCATION - GENERAL SERVICE COSTS					Provider CCN: 420087		PERIOD FROM 01/01/2011 TO 12/31/2011						WORKSHEET B, PART I	
41	Subprovider IRF	5,735,734	836,734	149,081	1,173,953	7,895,502	1,757,997		1,391,333	143,694	356,234	475,741	78,611	41
42	Subprovider (specify)													42
43	Nursery	1,009,844	60,606	11,353	195,971	1,277,774	284,507		100,777	3,248	25,803		9,959	43
44	Skilled Nursing Facility													44
45	Nursing Facility													45
46	Other Long Term Care													46
	ANCILLARY SERVICE COST CENTERS													
50	Operating Room	24,582,160	2,168,567	3,293,949	2,204,095	32,248,770	7,352,930		3,605,925	170,448	923,252		119,034	50
51	Recovery Room	1,983,216	146,391	71,109	400,096	2,600,812	579,092		243,421	74,264	62,325		22,372	51
52	Labor Room and Delivery Room	1,167,222	267,965	54,733	229,113	1,719,033	382,756		445,577	37,808	114,084		12,364	52
53	Anesthesiology													53
54	Radiology-Diagnostic	10,839,418	720,340	2,826,363	1,481,492	15,867,613	3,798,421		1,197,791	50,346	306,680		57,832	54
55	Radiology-Therapeutic	4,974,554	460,284	2,596,802	768,917	8,800,557	1,959,550		765,368	45,364	195,963		18,615	55
56	Radioisotope													56
57	Computed Tomography (CT) Scan	851,288	46,402	437,569	115,875	1,451,134	323,107		77,157		19,755		7,135	57
58	Magnetic Resonance Imaging (MRI)	424,488	65,369	105,768	64,570	660,195	146,998		108,696	15,094	27,830		4,191	58
59	Cardiac Catheterization	3,483,600	283,813	1,146,275	541,581	5,455,269	1,214,659		471,929	14,060	120,831		24,576	59
60	Laboratory	9,240,556	657,060	264,668	1,231,511	11,393,795	2,729,009		1,092,568		279,739		64,661	60
60.45	Vascular Lab	1,324,151	475,798	165,024	192,681	2,157,654	480,419		791,164	7,272	202,568		11,874	60.45
61	PBP Clinical Laboratory Services-Program Only													61
62	Whole Blood & Packed Red Blood Cells													62
63	Blood Storing, Processing, & Trans.	3,196,859	29,997	98,524	77,323	3,402,703	757,639		49,879		12,771		5,052	63
64														64
65	Respiratory Therapy	2,742,396	179,284	120,501	508,898	3,551,079	801,954		298,116	24,626	76,329		28,445	65
66	Physical Therapy	3,800,145	313,615	37,940	841,896	4,993,596	1,167,101		521,484	18,751	133,519		53,423	66
67	Occupational Therapy													67
68	Speech Pathology													68
69	Electrocardiology	674,431	87,149	431,968	145,228	1,338,776	298,089		144,913	15,648	37,103		9,573	69
70	Electroencephalography													70
71	Medical Supplies Charged to Patients													71
72	Implantable Devices Charged to Patients	25,066,800				25,066,800	5,581,324							72
73	Drugs Charged to Patients	21,391,064	175,301	294,700	1,200,272	23,061,336	5,268,516		291,494		74,633		49,345	73
74	Renal Dialysis													74
75	ASC (Non-Distinct Part)													75
76	Other Ancillary (specify)													76
76.30	Other Ancillary Cost Centers	1,321,103	31,445	130,611	188,753	1,671,912	372,264		52,287	6,726	13,388		10,088	76.30
	OUTPATIENT SERVICE COST CENTERS													
88	Rural Health Clinic (RHC)													88
89	Federally Qualified Health Center (FQHC)													89
90	Clinic													90

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COST ALLOCATION - GENERAL SERVICE COSTS					Provider CCN: 420087		PERIOD: FROM 01/01/2011 TO 12/31/2011						WORKSHEET B, PART I	
91	Emergency	8,124,085	651,629	310,419	1,518,724	10,604,857	2,747,736		1,083,537	123,720	277,426		51,581	91
92	Observation Beds													92
93	Other Outpatient Service (specify)													93
	OTHER REIMBURSABLE COST CENTERS													
94	Home Program Dialysis													94
95	Ambulance Services	1,961,475		147,405	375,498	2,484,378	553,167							95
96	Durable Medical Equipment-Rented													96
97	Durable Medical Equipment-Sold													97
98	Other Reimbursable (specify)													98
99	Outpatient Rehabilitation Provider (specify)													99
100	Intern-Resident Service (not appvd. tchng. prgm.)													100
101	Home Health Agency	6,430,005		126,374	1,311,037	7,867,416	1,751,743							101
	SPECIAL PURPOSE COST CENTERS													
105	Kidney Acquisition													105
106	Heart Acquisition													106
107	Liver Acquisition													107
108	Lung Acquisition													108
109	Pancreas Acquisition													109
110	Intestinal Acquisition													110
111	Islet Acquisition													111
112	Other Organ Acquisition (specify)													112
115	Ambulatory Surgical Center (Distinct Part)													115
116	Hospice													116
117	Other Special Purpose (specify)													117
118	SUBTOTALS (sum of lines 1-117)	321,851,840	21,401,944	15,049,206	26,020,276	321,469,376	60,030,982		24,891,028	1,797,171	6,120,690	6,352,182	1,156,779	118
	NONREIMBURSABLE COST CENTERS													
190	Gift, Flower, Coffee Shop, & Canteen			5,077	29,564	34,641	7,713					2,435,698	2,848	190
191	Research													191
192	Physicians' Private Offices													192
193	Nonpaid Workers													193
194	Other Nonreimbursable (specify)	1,020,519	37,489	14,032	296,300	1,368,340	304,672		62,337		15,961		2,405	194
200	Cross Foot Adjustments													200
201	Negative Cost Centers													201
202	TOTAL (sum lines 118-201)	322,872,352	21,439,432	15,068,315	26,346,140	322,872,352	60,343,366		24,953,364	1,797,171	6,136,651	8,787,880	1,162,032	202
FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4020)														
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[Record code 7200 - 2010]

COST ALLOCATION - GENERAL SERVICE COSTS				Provider CCN: 420087		PERIOD: FROM 01/01/2011 TO 12/31/2011		WORKSHEET B, PART I	
COST CENTER DESCRIPTIONS	MAIN- TENANCE OF PERSONNEL	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE	NON- PHYSICIAN ANES- THETISTS	
	12	13	14	15	16	17	18	19	
GENERAL SERVICE COST CENTERS									
1 Capital Related Costs-Buildings and Fixtures									1
2 Capital Related Costs-Movable Equipment									2
4 Employee Benefits									4
5 Administrative and General									5
5.05 Other Administrative & General									5 05
6 Maintenance and Repairs									6
7 Operation of Plant									7
8 Laundry and Linen Service									8
9 Housekeeping									9
10 Dietary									10
11 Cafeteria									11
12 Maintenance of Personnel									12
13 Nursing Administration		3,054,214							13
14 Central Services and Supply									14
15 Pharmacy									15
16 Medical Records & Medical Records Library					3,751,415				16
17 Social Service									17
18 Other General Service (specify)									18
19 Nonphysician Anesthetists									19
20 Nursing School									20
21 Intern & Res. Service-Salary & Fringes (Approved)									21
22 Intern & Res. Other Program Costs (Approved)									22
23 Paramedical Education Program (specify)									23
INPATIENT ROUTINE SERVICE COST CENTERS									
30 Adults and Pediatrics (General Routine Care)		1,418,722			952,728				30
31 Intensive Care Unit		294,629			295,356				31
32 Coronary Care Unit									32
33 Burn Intensive Care Unit									33
34 Surgical Intensive Care Unit									34
35 Other Special Care Unit (specify)									35
40 Subprovider IPF									40
41 Subprovider IRF		294,922			216,380				41

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COST ALLOCATION - GENERAL SERVICE COSTS				Provider CCN: 420087		PERIOD: FROM 01/01/2011 TO 12/31/2011		WORKSHEET B, PART I	
42	Subprovider (specify)								42
43	Nursery		37,365		22,772				43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
46	Other Long Term Care								46
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room		516,059		1,041,957				50
51	Recovery Room		85,375						51
52	Labor Room and Delivery Room		46,387						52
53	Anesthesiology								53
54	Radiology-Diagnostic								54
55	Radiology-Therapeutic								55
56	Radioisotope								56
57	Computed Tomography (CT) Scan								57
58	Magnetic Resonance Imaging (MRI)								58
59	Cardiac Catheterization				330,719				59
60	Laboratory								60
60.45	Vascular Lab								60 45
61	PBP Clinical Laboratory Services-Program Only								61
62	Whole Blood & Packed Red Blood Cells								62
63	Blood Storing, Processing, & Trans.								63
64									64
65	Respiratory Therapy								65
65.									65.
66	Physical Therapy								66
67	Occupational Therapy								67
68	Speech Pathology								68
69	Electrocardiology								69
70	Electroencephalography								70
71	Medical Supplies Charged to Patients								71
72	Implantable Devices Charged to Patients								72
73	Drugs Charged to Patients								73
74	Renal Dialysis								74
75	ASC (Non-Distinct Part)								75
76	Other Ancillary (specify)								76
76.30	Other Ancillary Cost Centers		37,838						76 30
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic (RHC)								88
89	Federally Qualified Health Center (FQHC)								89
90	Clinic								90

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COST ALLOCATION - GENERAL SERVICE COSTS				Provider CCN: 420087		PERIOD: FROM 01/01/2011 TO 12/31/2011		WORKSHEET B, PART I	
91	Emergency		322,917		891,503				91
92	Observation Beds								92
93	Other Outpatient Service (specify)								93
	OTHER REIMBURSABLE COST CENTERS								
94	Home Program Dialysis								94
95	Ambulance Services								95
96	Durable Medical Equipment-Rented								96
97	Durable Medical Equipment-Sold								97
98	Other Reimbursable (specify)								98
99	Outpatient Rehabilitation Provider (specify)								99
100	Intern-Resident Service (not appvd. tchng. prgm.)								100
101	Home Health Agency								101
	SPECIAL PURPOSE COST CENTERS								
105	Kidney Acquisition								105
106	Heart Acquisition								106
107	Liver Acquisition								107
108	Lung Acquisition								108
109	Pancreas Acquisition								109
110	Intestinal Acquisition								110
111	Islet Acquisition								111
112	Other Organ Acquisition (specify)								112
115	Ambulatory Surgical Center (Distinct Part)								115
116	Hospice								116
117	Other Special Purpose (specify)								117
118	SUBTOTALS (sum of lines 1-117)		3,054,214		3,751,415				118
	NONREIMBURSABLE COST CENTERS								
190	Gift, Flower, Coffee Shop, & Canteen								190
191	Research								191
192	Physicians' Private Offices								192
193	Nonpaid Workers								193
194	Other Nonreimbursable (specify)								194
200	Cross Foot Adjustments								200
201	Negative Cost Centers								201
202	TOTAL (sum lines 118-201)		3,054,214		3,751,415				202

FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4020)

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COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN 420087		PERIOD: FROM 01/01/2011 TO 12/31/2011		WORKSHEET B, PART I	
COST CENTER DESCRIPTIONS	NURSING SCHOOL	INTERNS & RESIDENTS SALARY AND FRINGES	INTERNS & RESIDENTS PROGRAM COSTS	PARAMEDICAL EDUCATION (SPECIFY)	SUBTOTAL	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS	TOTAL	
	20	21	22	23	24	25	26	
GENERAL SERVICE COST CENTERS								
1 Capital Related Costs-Buildings and Fixtures								1
2 Capital Related Costs-Movable Equipment								2
4 Employee Benefits								4
5 Administrative and General								5
5.05 Other Administrative & General								5.05
6 Maintenance and Repairs								6
7 Operation of Plant								7
8 Laundry and Linen Service								8
9 Housekeeping								9
10 Dietary								10
11 Cafeteria								11
12 Maintenance of Personnel								12
13 Nursing Administration								13
14 Central Services and Supply								14
15 Pharmacy								15
16 Medical Records & Medical Records Library								16
17 Social Service								17
18 Other General Service (specify)								18
19 Nonphysician Anesthetists								19
20 Nursing School								20
21 Intern & Res. Service-Salary & Fringes (Approved)								21
22 Intern & Res. Other Program Costs (Approved)								22
23 Paramedical Education Program (specify)				299,090				23
INPATIENT ROUTINE SERVICE COST CENTERS								
30 Adults and Pediatrics (General Routine Care)				167,268	65,761,036		65,761,036	30
31 Intensive Care Unit				61,993	15,223,558		15,223,558	31
32 Coronary Care Unit								32
33 Burn Intensive Care Unit								33
34 Surgical Intensive Care Unit								34
35 Other Special Care Unit (specify)								35
40 Subprovider IPF								40
41 Subprovider IRF				18,484	12,628,898		12,628,898	41

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COST ALLOCATION - GENERAL SERVICE COSTS				Provider CCN: 420087		PERIOD: FROM 01/01/2011 TO 12/31/2011		WORKSHEET B, PART I	
42	Subprovider (specify)								42
43	Nursery					1,762,205		1,762,205	43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
46	Other Long Term Care								46
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room				31,111	46,009,488		46,009,488	50
51	Recovery Room				4,031	3,671,692		3,671,692	51
52	Labor Room and Delivery Room				4,108	2,762,117		2,762,117	52
53	Anesthesiology								53
54	Radiology-Diagnostic					21,278,684		21,278,684	54
55	Radiology-Therapeutic				2,130	11,787,547		11,787,547	55
56	Radioisotope								56
57	Computed Tomography (CT) Scan					1,878,288		1,878,288	57
58	Magnetic Resonance Imaging (MRI)					963,004		963,004	58
59	Cardiac Catheterization					7,632,043		7,632,043	59
60	Laboratory					15,559,772		15,559,772	60
60.45	Vascular Lab					3,650,951		3,650,951	60 45
61	PBP Clinical Laboratory Services-Program Only								61
62	Whole Blood & Packed Red Blood Cells								62
63	Blood Storing, Processing, & Trans.					4,228,044		4,228,044	63
64									64
65	Respiratory Therapy					4,780,549		4,780,549	65
66	Physical Therapy					6,887,874		6,887,874	66
67	Occupational Therapy								67
68	Speech Pathology								68
69	Electrocardiology					1,844,102		1,844,102	69
70	Electroencephalography								70
71	Medical Supplies Charged to Patients								71
72	Implantable Devices Charged to Patients					30,648,124		30,648,124	72
73	Drugs Charged to Patients					28,745,324		28,745,324	73
74	Renal Dialysis								74
75	ASC (Non-Distinct Part)								75
76	Other Ancillary (specify)								76
76.30	Other Ancillary Cost Centers					2,164,503		2,164,503	76 30
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic (RHC)								88
89	Federally Qualified Health Center (FQHC)								89
90	Clinic								90
91	Emergency				9,965	16,113,242		16,113,242	91

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COST ALLOCATION - GENERAL SERVICE COSTS				Provider CCN: 420087	PERIOD: FROM 01/01/2011 TO 12/31/2011		WORKSHEET B, PART I	
92	Observation Beds							92
93	Other Outpatient Service (specify)							93
OTHER REIMBURSABLE COST CENTERS								
94	Home Program Dialysis							94
95	Ambulance Services				3,037,545		3,037,545	95
96	Durable Medical Equipment-Rented							96
97	Durable Medical Equipment-Sold							97
98	Other Reimbursable (specify)							98
99	Outpatient Rehabilitation Provider (specify)							99
100	Intern-Resident Service (not appvd. tchng. prgm.)							100
101	Home Health Agency				9,619,159		9,619,159	101
SPECIAL PURPOSE COST CENTERS								
105	Kidney Acquisition							105
106	Heart Acquisition							106
107	Liver Acquisition							107
108	Lung Acquisition							108
109	Pancreas Acquisition							109
110	Intestinal Acquisition							110
111	Islet Acquisition							111
112	Other Organ Acquisition (specify)							112
115	Ambulatory Surgical Center (Distinct Part)							115
116	Hospice							116
117	Other Special Purpose (specify)							117
118	SUBTOTALS (sum of lines 1-117)			299,090	318,637,760		318,637,760	118
NONREIMBURSABLE COST CENTERS								
190	Gift, Flower, Coffee Shop, & Canteen				2,480,900		2,480,900	190
191	Research							191
192	Physicians' Private Offices							192
193	Nonpaid Workers							193
194	Other Nonreimbursable (specify)				1,753,715		1,753,715	194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum lines 118-201)			299,090	322,872,352		322,872,352	202
FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4020)								
Rev. 2							4090 (Cont.) - 08-11	

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ALLOCATION OF CAPITAL-RELATED COSTS								Provider CCN: 420087		PERIOD: FROM 01/01/2011 TO 12/31/2011		WORKSHEET B, PART II	
COST CENTER DESCRIPTIONS	DIRECTLY ASSIGNED NEW CAPITAL RELATED COSTS	CAPITAL RELATED COSTS		SUBTOTAL (sum of cols. 0-2)	EMPLOYEE BENEFITS	ADMINIS-TRATIVE & GENERAL	MAIN-TENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	
		BLDGS. & FIXTURES	MOVABLE EQUIPMENT										
	0	1	2	2A	4	5	6	7	8	9	10	11	
GENERAL SERVICE COST CENTERS													
1 Capital Related Costs-Buildings and Fixtures													1
2 Capital Related Costs-Movable Equipment													2
4		101,465		101,465	101,465								4
5 Administrative and General													5
5.05 Other Administrative & General		1,870,772	156,807	2,027,579	7,878	2,049,389							5.05
6 Maintenance and Repairs													6
7 Operation of Plant		4,460,492	692,954	5,153,446	2,051	142,864		5,298,361					7
8 Laundry and Linen Service		57,932	263	58,195		9,738		20,454	88,387				8
9 Housekeeping		534,789	26,691	561,480	2,271	30,043		188,816		782,610			9
10 Dietary		472,957	89,080	562,037		44,657		166,985		25,679	799,358		10
11 Cafeteria											269,792	105,700	11
12 Maintenance of Personnel													12
13 Nursing Administration		105,058		105,058	1,485	16,119		37,093		5,704		1,755	13
14 Central Services and Supply													14
15 Pharmacy													15
16 Medical Records & Medical Records Library		197,332	8,685	206,017	1,593	18,898		69,671		10,714		3,490	16
17 Social Service													17
18 Other General Service (specify)													18
19 Nonphysician Anesthetists													19
20 Nursing School													20
21 Intern & Res. Service-Salary & Fringes (Approved)													21
22 Intern & Res. Other Program Costs (Approved)													22
23 Paramedical Education Program (specify)		26,042	44	26,086	118	1,380		9,194		1,414		334	23
INPATIENT ROUTINE SERVICE COST CENTERS													
30 Adults and Pediatrics (General Routine Care)		5,016,256	858,967	5,875,223	22,535	279,455		1,771,069	43,812	272,360	242,859	34,400	30
31 Intensive Care Unit		901,100	394,579	1,295,679	5,383	69,935		318,148	7,637	48,925	21,878	7,144	31
32 Coronary Care Unit													32
33 Burn Intensive Care Unit													33
34 Surgical Intensive Care Unit													34
35 Other Special Care Unit (specify)													35
40 Subprovider IPF													40

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ALLOCATION OF CAPITAL-RELATED COSTS								Provider CCN: 420087		PERIOD: FROM 01/01/2011 TO 12/31/2011		WORKSHEET B, PART II	
41	Subprovider IRF		836,734	149,081	985,815	4,523	55,269		295,423	7,067	45,431	43,274	7,151	41
42	Subprovider (specify)													42
43	Nursery		60,606	11,353	71,959	755	8,944		21,398	160	3,291		906	43
44	Skilled Nursing Facility													44
45	Nursing Facility													45
46	Other Long Term Care													46
	ANCILLARY SERVICE COST CENTERS													
50	Operating Room		2,168,567	3,293,949	5,462,516	8,492	251,762		765,648	8,383	117,743		10,827	50
51	Recovery Room		146,391	71,109	217,500	1,541	18,206		51,686	3,652	7,948		2,035	51
52	Labor Room and Delivery Room		267,965	54,733	322,698	883	12,033		94,610	1,859	14,549		1,125	52
53	Anesthesiology													53
54	Radiology-Diagnostic		720,340	2,826,363	3,546,703	5,708	151,107		254,328	2,476	39,111		5,260	54
55	Radiology-Therapeutic		460,284	2,596,802	3,057,086	2,962	61,609		162,511	2,231	24,991		1,693	55
56	Radioisotope													56
57	Computed Tomography (CT) Scan		46,402	437,569	483,971	446	10,158		16,383		2,519		649	57
58	Magnetic Resonance Imaging (MRI)		65,369	105,768	171,137	249	4,621		23,080	742	3,549		381	58
59	Cardiac Catheterization		283,813	1,146,275	1,430,088	2,087	38,187		100,205	691	15,410		2,235	59
60	Laboratory		657,060	264,668	921,728	4,745	108,736		231,986		35,675		5,882	60
60.45	Vascular Lab		475,798	165,024	640,822	742	15,104		167,988	358	25,834		1,080	60.45
61	PBP Clinical Laboratory Services-Program Only													61
62	Whole Blood & Packed Red Blood Cells													62
63	Blood Storing, Processing, & Trans.		29,997	98,524	128,521	298	23,819		10,591		1,629		460	63
64	Intravenous Therapy													64
65	Respiratory Therapy		179,284	120,501	299,785	1,961	26,559		63,299	1,211	9,734		2,587	65
66	Physical Therapy		313,615	37,940	351,555	3,244	43,288		110,727	922	17,028		4,859	66
67	Occupational Therapy													67
68	Speech Pathology													68
69	Electrocardiology		87,149	431,968	519,117	560	9,371		30,769	770	4,732		871	69
70	Electroencephalography													70
71	Medical Supplies Charged to Patients													71
72	Implantable Devices Charged to Patients						175,468							72
73	Drugs Charged to Patients		175,301	294,700	470,001	4,624	181,603		61,893		9,518		4,488	73
74	Renal Dialysis													74
75	ASC (Non-Distinct Part)													75
76	Other Ancillary (specify)													76
76.30	Other Ancillary Cost Centers		31,445	130,611	162,056	727	11,704		11,102	331	1,707		918	76.30
	OUTPATIENT SERVICE COST CENTERS													
88	Rural Health Clinic (RHC)													88
89	Federally Qualified Health Center (FQHC)													89
90	Clinic													90

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ALLOCATION OF CAPITAL-RELATED COSTS								Provider CCN: 420087		PERIOD: FROM 01/01/2011 TO 12/31/2011		WORKSHEET B, PART II	
91	Emergency		651,629	310,419	962,048	5,851	132,537		230,068	6,085	35,380		4,692	91
92	Observation Beds													92
93	Other Outpatient Service (specify)													93
	OTHER REIMBURSABLE COST CENTERS													
94	Home Program Dialysis													94
95	Ambulance Services			147,405	147,405	1,447	17,391							95
96	Durable Medical Equipment-Rented													96
97	Durable Medical Equipment-Sold													97
98	Other Reimbursable (specify)													98
99	Outpatient Rehabilitation Provider (specify)													99
100	Intern-Resident Service (not appvd. tchng. prgm.)													100
101	Home Health Agency			126,374	126,374	5,051	55,072							101
	SPECIAL PURPOSE COST CENTERS													
105	Kidney Acquisition													105
106	Heart Acquisition													106
107	Liver Acquisition													107
108	Lung Acquisition													108
109	Pancreas Acquisition													109
110	Intestinal Acquisition													110
111	Islet Acquisition													111
112	Other Organ Acquisition (specify)													112
115	Ambulatory Surgical Center (Distinct Part)													115
116	Hospice													116
117	Other Special Purpose (specify)													117
118	SUBTOTALS (sum of lines 1-117)		21,401,944	15,049,206	36,451,152	100,210	2,032,603		5,285,125	88,387	780,575	577,803	105,222	118
	NONREIMBURSABLE COST CENTERS													
190	Gift, Flower, Coffee Shop, & Canteen			5,077	5,077	114	242					221,555	259	190
191	Research													191
192	Physicians' Private Offices													192
193	Nonpaid Workers													193
194	Other Nonreimbursable (specify)		37,489	14,032	51,521	1,141	9,578		13,236		2,035		219	194
200	Cross Foot Adjustments													200
201	Negative Cost Centers												164,092	201
202	TOTAL (sum lines 118-201)		21,439,432	15,068,315	36,507,748	101,465	2,042,423		5,298,361	88,387	782,610	799,358	269,792	202
FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4021)														
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ALLOCATION OF CAPITAL-RELATED COSTS					Provider CCN: 420087		PERIOD: FROM 01/01/2011 TO 12/31/2011		WORKSHEET B, PART II	
COST CENTER DESCRIPTIONS	CAFETERIA	MAIN- TENANCE OF PERSONNEL	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE	NON- PHYSICIAN ANES- THETISTS	
	11	12	13	14	15	16	17	18	19	
GENERAL SERVICE COST CENTERS										
1 Capital Related Costs-Buildings and Fixtures										1
2 Capital Related Costs-Movable Equipment										2
4										4
5 Administrative and General										5
5.05 Other Administrative & General										5 05
6 Maintenance and Repairs										6
7 Operation of Plant										7
8 Laundry and Linen Service										8
9 Housekeeping										9
10 Dietary										10
11 Cafeteria	105,700									11
12 Maintenance of Personnel										12
13 Nursing Administration	1,755		167,214							13
14 Central Services and Supply										14
15 Pharmacy										15
16 Medical Records & Medical Records Library	3,490					310,383				16
17 Social Service										17
18 Other General Service (specify)										18
19 Nonphysician Anesthetists										19
20 Nursing School										20
21 Intern & Res. Service-Salary & Fringes (Approved)										21
22 Intern & Res. Other Program Costs (Approved)										22
23 Paramedical Education Program (specify)	334									23
INPATIENT ROUTINE SERVICE COST CENTERS										
30 Adults and Pediatrics (General Routine Care)	34,400		77,671			78,814				30
31 Intensive Care Unit	7,144		16,131			24,433				31
32 Coronary Care Unit										32
33 Burn Intensive Care Unit										33
34 Surgical Intensive Care Unit										34
35 Other Special Care Unit (specify)										35
40 Subprovider IPF										40
41 Subprovider IRF	7,151		16,147			17,900				41

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ALLOCATION OF CAPITAL-RELATED COSTS						Provider CCN: 420087		PERIOD: FROM 01/01/2011 TO 12/31/2011		WORKSHEET B, PART II	
42	Subprovider (specify)										42
43	Nursery	906		2,046			1,884				43
44	Skilled Nursing Facility										44
45	Nursing Facility										45
46	Other Long Term Care										46
	ANCILLARY SERVICE COST CENTERS										
50	Operating Room	10,827		28,254			86,244				50
51	Recovery Room	2,035		4,674							51
52	Labor Room and Delivery Room	1,125		2,540							52
53	Anesthesiology										53
54	Radiology-Diagnostic	5,260									54
55	Radiology-Therapeutic	1,693									55
56	Radioisotope										56
57	Computed Tomography (CT) Scan	649									57
58	Magnetic Resonance Imaging (MRI)	381									58
59	Cardiac Catheterization	2,235					27,359				59
60	Laboratory	5,882									60
60.45	Vascular Lab	1,080									60.45
61	PBP Clinical Laboratory Services-Program Only										61
62	Whole Blood & Packed Red Blood Cells										62
63	Blood Storing, Processing, & Trans.	460									63
64	Intravenous Therapy										64
65	Respiratory Therapy	2,587									65
66	Physical Therapy	4,859									66
67	Occupational Therapy										67
68	Speech Pathology										68
69	Electrocardiology	871									69
70	Electroencephalography										70
71	Medical Supplies Charged to Patients										71
72	Implantable Devices Charged to Patients										72
73	Drugs Charged to Patients	4,488									73
74	Renal Dialysis										74
75	ASC (Non-Distinct Part)										75
76	Other Ancillary (specify)										76
76.30	Other Ancillary Cost Centers	918		2,072							76 30
	OUTPATIENT SERVICE COST CENTERS										
88	Rural Health Clinic (RHC)										88
89	Federally Qualified Health Center (FQHC)										89
90	Clinic										90
91	Emergency	4,692		17,679			73,749				91

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ALLOCATION OF CAPITAL-RELATED COSTS					Provider CCN: 420087		PERIOD: FROM 01/01/2011 TO 12/31/2011		WORKSHEET B, PART II	
92	Observation Beds									92
93	Other Outpatient Service (specify)									93
	OTHER REIMBURSABLE COST CENTERS									
94	Home Program Dialysis									94
95	Ambulance Services									95
96	Durable Medical Equipment-Rented									96
97	Durable Medical Equipment-Sold									97
98	Other Reimbursable (specify)									98
99	Outpatient Rehabilitation Provider (specify)									99
100	Intern-Resident Service (not appvd. tchng. prgm.)									100
101	Home Health Agency									101
	SPECIAL PURPOSE COST CENTERS									
105	Kidney Acquisition									105
106	Heart Acquisition									106
107	Liver Acquisition									107
108	Lung Acquisition									108
109	Pancreas Acquisition									109
110	Intestinal Acquisition									110
111	Islet Acquisition									111
112	Other Organ Acquisition (specify)									112
115	Ambulatory Surgical Center (Distinct Part)									115
116	Hospice									116
117	Other Special Purpose (specify)									117
118	SUBTOTALS (sum of lines 1-117)	105,222		167,214			310,383			118
	NONREIMBURSABLE COST CENTERS									
190	Gift, Flower, Coffee Shop, & Canteen	259								190
191	Research									191
192	Physicians' Private Offices									192
193	Nonpaid Workers									193
194	Other Nonreimbursable (specify)	219								194
200	Cross Foot Adjustments									200
201	Negative Cost Centers	164,092								201
202	TOTAL (sum lines 118-201)	269,792		167,214			310,383			202
FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4021)										
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ALLOCATION OF CAPITAL-RELATED COSTS			Provider CCN: 420087		PERIOD: FROM 01/01/2011 TO 12/31/2011		WORKSHEET B, PART II	
COST CENTER DESCRIPTIONS	NURSING SCHOOL	INTERNS & RESIDENTS SALARY AND FRINGES	INTERNS & RESIDENTS PROGRAM COSTS	PARAMEDICAL EDUCATION (SPECIFY)	SUBTOTAL	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS	TOTAL	
	20	21	22	23	24	25	26	
GENERAL SERVICE COST CENTERS								
1 Capital Related Costs-Buildings and Fixtures								1
2 Capital Related Costs-Movable Equipment								2
4								4
5 Administrative and General								5
5.05 Other Administrative & General								5 05
6 Maintenance and Repairs								6
7 Operation of Plant								7
8 Laundry and Linen Service								8
9 Housekeeping								9
10 Dietary								10
11 Cafeteria								11
12 Maintenance of Personnel								12
13 Nursing Administration								13
14 Central Services and Supply								14
15 Pharmacy								15
16 Medical Records & Medical Records Library								16
17 Social Service								17
18 Other General Service (specify)								18
19 Nonphysician Anesthetists								19
20 Nursing School								20
21 Intern & Res. Service-Salary & Fringes (Approved)								21
22 Intern & Res Other Program Costs (Approved)								22
23 Paramedical Education Program (specify)				38,526				23
INPATIENT ROUTINE SERVICE COST CENTERS								
30 Adults and Pediatrics (General Routine Care)					8,698,198		8,698,198	30
31 Intensive Care Unit					1,815,293		1,815,293	31
32 Coronary Care Unit								32
33 Burn Intensive Care Unit								33
34 Surgical Intensive Care Unit								34
35 Other Special Care Unit (specify)								35
40 Subprovider IPF								40
41 Subprovider IRF					1,478,000		1,478,000	41

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ALLOCATION OF CAPITAL-RELATED COSTS		Provider CCN: 420087	PERIOD: FROM 01/01/2011 TO 12/31/2011		WORKSHEET B, PART II	
42	Subprovider (specify)					42
43	Nursery		111,343		111,343	43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
46	Other Long Term Care					46
	ANCILLARY SERVICE COST CENTERS					
50	Operating Room		6,739,869		6,739,869	50
51	Recovery Room		307,242		307,242	51
52	Labor Room and Delivery Room		450,297		450,297	52
53	Anesthesiology					53
54	Radiology-Diagnostic		4,004,693		4,004,693	54
55	Radiology-Therapeutic		3,313,083		3,313,083	55
56	Radioisotope					56
57	Computed Tomography (CT) Scan		514,126		514,126	57
58	Magnetic Resonance Imaging (MRI)		203,759		203,759	58
59	Cardiac Catheterization		1,616,262		1,616,262	59
60	Laboratory		1,308,752		1,308,752	60
60.45	Vascular Lab		851,928		851,928	60 45
61	PBP Clinical Laboratory Services-Program Only					61
62	Whole Blood & Packed Red Blood Cells					62
63	Blood Storing, Processing, & Trans.		165,318		165,318	63
64	Intravenous Therapy					64
65	Respiratory Therapy		405,136		405,136	65
66	Physical Therapy		531,623		531,623	66
67	Occupational Therapy					67
68	Speech Pathology					68
69	Electrocardiology		566,190		566,190	69
70	Electroencephalography					70
71	Medical Supplies Charged to Patients					71
72	Implantable Devices Charged to Patients		175,468		175,468	72
73	Drugs Charged to Patients		732,127		732,127	73
74	Renal Dialysis					74
75	ASC (Non-Distinct Part)					75
76	Other Ancillary (specify)					76
76.30	Other Ancillary Cost Centers		190,617		190,617	76.30
	OUTPATIENT SERVICE COST CENTERS					
88	Rural Health Clinic (RHC)					88
89	Federally Qualified Health Center (FQHC)					89
90	Clinic					90
91	Emergency		1,468,089		1,468,089	91

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ALLOCATION OF CAPITAL-RELATED COSTS			Provider CCN: 420087		PERIOD: FROM 01/01/2011 TO 12/31/2011		WORKSHEET B, PART II	
92	Observation Beds							92
93	Other Outpatient Service (specify)							93
	OTHER REIMBURSABLE COST CENTERS							
94	Home Program Dialysis							94
95	Ambulance Services				166,243		166,243	95
96	Durable Medical Equipment-Rented							96
97	Durable Medical Equipment-Sold							97
98	Other Reimbursable (specify)							98
99	Outpatient Rehabilitation Provider (specify)							99
100	Intern-Resident Service (not appvd. tchng. prgm.)							100
101	Home Health Agency				186,497		186,497	101
	SPECIAL PURPOSE COST CENTERS							
105	Kidney Acquisition							105
106	Heart Acquisition							106
107	Liver Acquisition							107
108	Lung Acquisition							108
109	Pancreas Acquisition							109
110	Intestinal Acquisition							110
111	Islet Acquisition							111
112	Other Organ Acquisition (specify)							112
115	Ambulatory Surgical Center (Distinct Part)							115
116	Hospice							116
117	Other Special Purpose (specify)							117
118	SUBTOTALS (sum of lines 1-117)				36,000,152		36,000,152	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop, & Canteen				227,247		227,247	190
191	Research							191
192	Physicians' Private Offices							192
193	Nonpaid Workers							193
194	Other Nonreimbursable (specify)				77,730		77,730	194
200	Cross Foot Adjustments			38,526	38,526		38,526	200
201	Negative Cost Centers				164,092		164,092	201
202	TOTAL (sum lines 118-201)			38,526	36,507,748		36,507,748	202
FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4021)								
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COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 420087 | PERIOD: FROM 01/01/2011 TO 12/31/2011 | WORKSHEET B-1

	COST CENTER DESCRIPTIONS	CAPITAL RELATED COST BLDGS. & FIXTURES (SQUARE FEET)	CAPITAL RELATED COST MOVABLE EQUIPMENT (DOLLAR VALUE)	EMPLOYEE BENEFITS (GROSS SALARIES)	RECONCILIATION	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	
		1	2	4	5A	5	6	7	8	9	10	11	
	GENERAL SERVICE COST CENTERS												
1	Capital Related Costs-Buildings and Fixtures	769,759											1
2	Capital Related Costs-Movable Equipment		8,595,269										2
4	Employee Benefits	3,643		116,536,496									4
5	Administrative and General												5
5.05	Other Administrative & General	67,168	89,446	9,044,699	-59,126,668	271,242,229							5.05
6	Maintenance and Repairs												6
7	Operation of Plant	160,149	395,275	2,355,250		20,409,112		538,799					7
8	Laundry and Linen Service	2,080	150			1,391,100		2,080	2,046,275				8
9	Housekeeping	19,201	15,225	2,607,532		4,291,794		19,201		517,518			9
10	Dietary	16,981	50,813			6,379,611		16,981		16,981	817,053		10
11	Cafeteria				1,803,981	-1					275,765	144,451	11
12	Maintenance of Personnel												12
13	Nursing Administration	3,772		1,705,094		2,302,766		3,772		3,772		2,399	13
14	Central Services and Supply												14
15	Pharmacy												15
16	Medical Records & Medical Records Library	7,085	4,954	1,828,425		2,699,783		7,085		7,085		4,769	16
17	Social Service												17
18	Other General Service (specify)												18
19	Nonphysician Anesthetists												19
20	Nursing School												20
21	Intern & Res Service-Salary & Fringes (Approved)												21
22	Intern & Res. Other Program Costs (Approved)												22
23	Paramedical Education Program (specify)	935	25	135,538		197,138		935		935		456	23
	INPATIENT ROUTINE SERVICE COST CENTERS												
30	Adults and Pediatrics (General Routine Care)	180,103	489,972	25,917,138		39,918,576		180,103	1,014,286	180,103	248,235	47,011	30
31	Intensive Care Unit	32,353	225,076	6,180,552		9,990,723		32,353	176,815	32,353	22,362	9,763	31
32	Coronary Care Unit												32
33	Burn Intensive Care Unit												33
34	Surgical Intensive Care Unit												34
35	Other Special Care Unit (specify)												35
40	Subprovider IPF												40

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COST ALLOCATION - STATISTICAL BASIS							Provider CCN: 420087		PERIOD: FROM 01/01/2011 TO 12/31/2011		WORKSHEET B-1	
41	Subprovider IRF	30,042	85,039	5,192,735		7,895,502	30,042	163,611	30,042	44,232	9,772	41
42	Subprovider (specify)											42
43	Nursery	2,176	6,476	866,837		1,277,774	2,176	3,698	2,176		1,238	43
44	Skilled Nursing Facility											44
45	Nursing Facility											45
46	Other Long Term Care											46
ANCILLARY SERVICE COST CENTERS												
50	Operating Room	77,860	1,878,935	9,749,355		32,914,692	77,860	194,074	77,860		14,797	50
51	Recovery Room	5,256	40,562	1,769,741		2,600,812	5,256	84,558	5,256		2,781	51
52	Labor Room and Delivery Room	9,621	31,221	1,013,432		1,719,033	9,621	43,049	9,621		1,537	52
53	Anesthesiology											53
54	Radiology-Diagnostic	25,863	1,612,214	6,553,069		16,892,151	25,863	57,324	25,863		7,189	54
55	Radiology-Therapeutic	16,526	1,481,268	3,401,142		8,800,696	16,526	51,652	16,526		2,314	55
56	Radioisotope											56
57	Computed Tomography (CT) Scan	1,666	249,598	512,551		1,451,134	1,666		1,666		887	57
58	Magnetic Resonance Imaging (MRI)	2,347	60,332	285,610		660,195	2,347	17,186	2,347		521	58
59	Cardiac Catheterization	10,190	653,858	2,395,572		5,455,269	10,190	16,009	10,190		3,055	59
60	Laboratory	23,591	150,972	5,447,330		12,135,411	23,591		23,591		8,038	60
60.45	Vascular Lab	17,083	94,133	852,284		2,157,654	17,083	8,280	17,083		1,476	60.45
61	PBP Clinical Laboratory Services-Program Only											61
62	Whole Blood & Packed Red Blood Cells											62
63	Blood Storing, Processing, & Trans	1,077	56,200	342,023		3,402,703	1,077		1,077		628	63
64	Intravenous Therapy											64
65	Respiratory Therapy	6,437	68,736	2,251,006		3,594,620	6,437	28,039	6,437		3,536	65
66	Physical Therapy	11,260	21,642	3,723,950		5,206,855	11,260	21,350	11,260		6,641	66
67	Occupational Therapy											67
68	Speech Pathology											68
69	Electrocardiology	3,129	246,403	642,386		1,338,776	3,129	17,817	3,129		1,190	69
70	Electroencephalography											70
71	Medical Supplies Charged to Patients											71
72	Implantable Devices Charged to Patients					25,066,800						72
73	Drugs Charged to Patients	6,294	168,103	5,309,154		23,577,621	6,294		6,294		6,134	73
74	Renal Dialysis											74
75	ASC (Non-Distinct Part)											75
76	Other Ancillary (specify)											76
76.30	Other Ancillary Cost Centers	1,129	74,503	834,909		1,671,912	1,129	7,658	1,129		1,254	76.30
OUTPATIENT SERVICE COST CENTERS												
88	Rural Health Clinic (RHC)											88
89	Federally Qualified Health Center (FQHC)											89
90	Clinic											90

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COST ALLOCATION - STATISTICAL BASIS							Provider CCN: 420087		PERIOD: FROM 01/01/2011 TO 12/31/2011		WORKSHEET B-1	
91	Emergency	23,396	177,069	6,717,759		12,096,981	23,396	140,869	23,396		6,412	91
92	Observation Beds											92
93	Other Outpatient Service (specify)											93
OTHER REIMBURSABLE COST CENTERS												
94	Home Program Dialysis											94
95	Ambulance Services		84,083	1,660,939		2,484,378						95
96	Durable Medical Equipment-Rented											96
97	Durable Medical Equipment-Sold											97
98	Other Reimbursable (specify)											98
99	Outpatient Rehabilitation Provider (specify)											99
100	Intern-Resident Service (not apprvd. tchng. prgm.)											100
101	Home Health Agency		72,086	5,799,100		7,867,416						101
SPECIAL PURPOSE COST CENTERS												
105	Kidney Acquisition											105
106	Heart Acquisition											106
107	Liver Acquisition											107
108	Lung Acquisition											108
109	Pancreas Acquisition											109
110	Intestinal Acquisition											110
111	Islet Acquisition											111
112	Other Organ Acquisition (specify)											112
115	Ambulatory Surgical Center (Distinct Part)											115
116	Hospice											116
117	Other Special Purpose (specify)											117
118	SUBTOTALS (sum of lines 1-117)	768,413	8,584,369	115,095,112	-57,322,688	268,844,112	537,453	2,046,275	516,172	590,594	143,798	118
NONREIMBURSABLE COST CENTERS												
190	Gift, Flower, Coffee Shop, & Canteen		2,896	130,769		34,641				226,459	354	190
191	Research											191
192	Physicians' Private Offices											192
193	Nonpaid Workers											193
194	Other Nonreimbursable (specify)	1,346	8,004	1,310,618		1,368,340	1,346		1,346		299	194
200	Cross foot adjustments											200
201	Negative cost centers											201
202	Cost to be allocated (per Worksheet B, Part I)	21,439,432	15,068,315	26,346,140		60,343,366	24,953,364	1,797,171	6,136,651	8,787,880	1,162,032	202
203	Unit cost multiplier (Worksheet B, Part I)	27.85	1.75	0.226076		0.481672	46.31	0 878265	11.86	10 76	8.04	203
204	Cost to be allocated (per Worksheet B, Part II)			101,465		2,042,423	5,298,361	88,387	782,610	799,358	269,792	204
205	Unit cost multiplier (Worksheet B, Part II)			0.000871		0.046075	9.83	0.043194	1.51	0.978343	0.731736	205
FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB 15-II, SECTION 4020)												
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COST ALLOCATION - STATISTICAL BASIS				Provider CCN: 420087		PERIOD: FROM 01/01/2011 TO 12/31/2011		WORKSHEET B-1	
COST CENTER DESCRIPTIONS	MAIN- TENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINIS-TRATION (DIRECT NURS. HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	OTHER GENERAL SERVICE (SPECIFY)	NON- PHYSICIAN ANES- THETISTS (ASGND TIME)	
	12	13	14	15	16	17	18	19	
GENERAL SERVICE COST CENTERS									
1 Capital Related Costs-Buildings and Fixtures									1
2 Capital Related Costs-Movable Equipment									2
4 Employee Benefits									4
5 Administrative and General									5
5.05 Other Administrative & General									5.05
6 Maintenance and Repairs									6
7 Operation of Plant									7
8 Laundry and Linen Service									8
9 Housekeeping									9
10 Dietary									10
11 Cafeteria									11
12 Maintenance of Personnel									12
13 Nursing Administration		2,105,046							13
14 Central Services and Supply									14
15 Pharmacy									15
16 Medical Records & Medical Records Library					385,972,768				16
17 Social Service									17
18 Other General Service (specify)									18
19 Nonphysician Anesthetists									19
20 Nursing School									20
21 Intern & Res. Service-Salary & Fringes (Approved)									21
22 Intern & Res. Other Program Costs (Approved)									22
23 Paramedical Education Program (specify)									23
INPATIENT ROUTINE SERVICE COST CENTERS									
30 Adults and Pediatrics (General Routine Care)		977,821			98,027,328				30
31 Intensive Care Unit		203,066			30,389,596				31
32 Coronary Care Unit									32
33 Burn Intensive Care Unit									33
34 Surgical Intensive Care Unit									34
35 Other Special Care Unit (specify)									35
40 Subprovider IPF									40
41 Subprovider IRF		203,268			22,263,564				41

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COST ALLOCATION - STATISTICAL BASIS				Provider CCN: 420087		PERIOD: FROM 01/01/2011 TO 12/31/2011		WORKSHEET B-1	
42	Subprovider (specify)								42
43	Nursery		25,753			2,343,037			43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
46	Other Long Term Care								46
ANCILLARY SERVICE COST CENTERS									
50	Operating Room		355,682			107,193,256			50
51	Recovery Room		58,843						51
52	Labor Room and Delivery Room		31,971						52
53	Anesthesiology								53
54	Radiology-Diagnostic								54
55	Radiology-Therapeutic								55
56	Radioisotope								56
57	Computed Tomography (CT) Scan								57
58	Magnetic Resonance Imaging (MRI)								58
59	Cardiac Catheterization					34,028,100			59
60	Laboratory								60
60.45	Vascular Lab								60.45
61	PBP Clinical Laboratory Services-Program Only								61
62	Whole Blood & Packed Red Blood Cells								62
63	Blood Storing, Processing, & Trans.								63
64	Intravenous Therapy								64
65	Respiratory Therapy								65
66	Physical Therapy								66
67	Occupational Therapy								67
68	Speech Pathology								68
69	Electrocardiology								69
70	Electroencephalography								70
71	Medical Supplies Charged to Patients								71
72	Implantable Devices Charged to Patients								72
73	Drugs Charged to Patients								73
74	Renal Dialysis								74
75	ASC (Non-Distinct Part)								75
76	Other Ancillary (specify)								76
76.30	Other Ancillary Cost Centers		26,079						76.30
OUTPATIENT SERVICE COST CENTERS									
88	Rural Health Clinic (RHC)								88
89	Federally Qualified Health Center (FQHC)								89
90	Clinic								90
91	Emergency		222,563			91,727,888			91

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COST ALLOCATION - STATISTICAL BASIS				Provider CCN: 420087		PERIOD: FROM 01/01/2011 TO 12/31/2011		WORKSHEET B-1	
92	Observation Beds								92
93	Other Outpatient Service (specify)								93
OTHER REIMBURSABLE COST CENTERS									
94	Home Program Dialysis								94
95	Ambulance Services								95
96	Durable Medical Equipment-Rented								96
97	Durable Medical Equipment-Sold								97
98	Other Reimbursable (specify)								98
99	Outpatient Rehabilitation Provider (specify)								99
100	Intern-Resident Service (not appvd. tchng. prgm.)								100
101	Home Health Agency								101
SPECIAL PURPOSE COST CENTERS									
105	Kidney Acquisition								105
106	Heart Acquisition								106
107	Liver Acquisition								107
108	Lung Acquisition								108
109	Pancreas Acquisition								109
110	Intestinal Acquisition								110
111	Islet Acquisition								111
112	Other Organ Acquisition (specify)								112
115	Ambulatory Surgical Center (Distinct Part)								115
116	Hospice								116
117	Other Special Purpose (specify)								117
118	SUBTOTALS (sum of lines 1-117)		2,105,046			385,972,768			118
NONREIMBURSABLE COST CENTERS									
190	Gift, Flower, Coffee Shop, & Canteen								190
191	Research								191
192	Physicians' Private Offices								192
193	Nonpaid Workers								193
194	Other Nonreimbursable (specify)								194
200	Cross foot adjustments								200
201	Negative cost centers								201
202	Cost to be allocated (per Worksheet B, Part I)		3,054,214			3,751,415			202
203	Unit cost multiplier (Worksheet B, Part I)		1.450901			0.009719			203
204	Cost to be allocated (per Worksheet B, Part II)		167,214			310,383			204
205	Unit cost multiplier (Worksheet B, Part II)		0.079435			0.000804			205
FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4020)									
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COST ALLOCATION - STATISTICAL BASIS			Provider CCN: 420087		PERIOD: FROM 01/01/2011 TO 12/31/2011		WORKSHEET B-1	
COST CENTER DESCRIPTIONS	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS		PARA- MEDICAL EDUCATION (ASSIGNED TIME)	SUBTOTAL	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS	TOTAL	
		SALARY AND FRINGES (ASSIGNED TIME)	PROGRAM COSTS (ASSIGNED TIME)					
	20	21	22	23	24	25	26	
GENERAL SERVICE COST CENTERS								
1 Capital Related Costs-Buildings and Fixtures								1
2 Capital Related Costs-Movable Equipment								2
4 Employee Benefits								4
5 Administrative and General								5
5.05 Other Administrative & General								5 05
6 Maintenance and Repairs								6
7 Operation of Plant								7
8 Laundry and Linen Service								8
9 Housekeeping								9
10 Dietary								10
11 Cafeteria								11
12 Maintenance of Personnel								12
13 Nursing Administration								13
14 Central Services and Supply								14
15 Pharmacy								15
16 Medical Records & Medical Records Library								16
17 Social Service								17
18 Other General Service (specify)								18
19 Nonphysician Anesthetists								19
20 Nursing School								20
21 Intern & Res. Service-Salary & Fringes (Approved)								21
22 Intern & Res. Other Program Costs (Approved)								22
23 Paramedical Education Program (specify)				3,932				23
INPATIENT ROUTINE SERVICE COST CENTERS								
30 Adults and Pediatrics (General Routine Care)				2,199				30
31 Intensive Care Unit				815				31
32 Coronary Care Unit								32
33 Burn Intensive Care Unit								33
34 Surgical Intensive Care Unit								34
35 Other Special Care Unit (specify)								35
40 Subprovider IPF								40
41 Subprovider IRF				243				41

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COST ALLOCATION - STATISTICAL BASIS				Provider CCN: 420087		PERIOD: FROM 01/01/2011 TO 12/31/2011		WORKSHEET B-1	
42	Subprovider (specify)								42
43	Nursery								43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
46	Other Long Term Care.								46
ANCILLARY SERVICE COST CENTERS									
50	Operating Room				409				50
51	Recovery Room				53				51
52	Labor Room and Delivery Room				54				52
53	Anesthesiology								53
54	Radiology-Diagnostic								54
55	Radiology-Therapeutic				28				55
56	Radioisotope								56
57	Computed Tomography (CT) Scan								57
58	Magnetic Resonance Imaging (MRI)								58
59	Cardiac Catheterization								59
60	Laboratory								60
60.45	Vascular Lab								60 45
61	PBP Clinical Laboratory Services-Program Only								61
62	Whole Blood & Packed Red Blood Cells								62
63	Blood Storing, Processing, & Trans.								63
64	Intravenous Therapy								64
65	Respiratory Therapy								65
66	Physical Therapy								66
67	Occupational Therapy								67
68	Speech Pathology								68
69	Electrocardiology								69
70	Electroencephalography								70
71	Medical Supplies Charged to Patients								71
72	Implantable Devices Charged to Patients								72
73	Drugs Charged to Patients								73
74	Renal Dialysis								74
75	ASC (Non-Distinct Part)								75
76	Other Ancillary (specify)								76
76.30	Other Ancillary Cost Centers								76.30
OUTPATIENT SERVICE COST CENTERS									
88	Rural Health Clinic (RHC)								88
89	Federally Qualified Health Center (FQHC)								89
90	Clinic								90
91	Emergency				131				91

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COST ALLOCATION - STATISTICAL BASIS				Provider CCN: 420087		PERIOD FROM 01/01/2011 TO 12/31/2011		WORKSHEET B-1	
92	Observation Beds								92
93	Other Outpatient Service (specify)								93
OTHER REIMBURSABLE COST CENTERS									
94	Home Program Dialysis								94
95	Ambulance Services								95
96	Durable Medical Equipment-Rented								96
97	Durable Medical Equipment-Sold								97
98	Other Reimbursable (specify)								98
99	Outpatient Rehabilitation Provider (specify)								99
100	Intern-Resident Service (not appvd. tchng. prgm.)								100
101	Home Health Agency								101
SPECIAL PURPOSE COST CENTERS									
105	Kidney Acquisition								105
106	Heart Acquisition								106
107	Liver Acquisition								107
108	Lung Acquisition								108
109	Pancreas Acquisition								109
110	Intestinal Acquisition								110
111	Islet Acquisition								111
112	Other Organ Acquisition (specify)								112
115	Ambulatory Surgical Center (Distinct Part)								115
116	Hospice								116
117	Other Special Purpose (specify)								117
118	SUBTOTALS (sum of lines 1-117)				3,932				118
NONREIMBURSABLE COST CENTERS									
190	Gift, Flower, Coffee Shop, & Canteen								190
191	Research								191
192	Physicians' Private Offices								192
193	Nonpaid Workers								193
194	Other Nonreimbursable (specify)								194
200	Cross foot adjustments								200
201	Negative cost centers								201
202	Cost to be allocated (per Worksheet B, Part I)				299,090				202
203	Unit cost multiplier (Worksheet B, Part I)				76.07				203
204	Cost to be allocated (per Worksheet B, Part II)				38,526				204
205	Unit cost multiplier (Worksheet B, Part II)				9.80				205
FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4020)									
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COMPUTATION OF RATIO OF COSTS TO CHARGES					Provider CCN: 420087			PERIOD: FROM 01/01/2011 TO 12/31/2011		WORKSHEET C PART 1	
COST CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
			Total Costs	RCE Disallowance	Total Costs	Inpatient	Outpatient	Total (column 6 + column 7)				
	1	2	3	4	5	6	7	8	9	10	11	
INPATIENT ROUTINE SERVICE COST CENTERS												
30 Adults and Pediatrics (General Routine Care)	65,761,036		65,761,036		65,761,036	96,921,408		96,921,408				30
31 Intensive Care Unit	15,223,558		15,223,558		15,223,558	30,389,596		30,389,596				31
32 Coronary Care Unit												32
33 Burn Intensive Care Unit												33
34 Surgical Intensive Care Unit												34
35 Other Special Care (specify)												35
40 Subprovider IPF												40
41 Subprovider IRF	12,628,898		12,628,898		12,628,898	22,263,564		22,263,564				41
42 Subprovider (Specify)												42
43 Nursery	1,762,205		1,762,205		1,762,205	2,343,037		2,343,037				43
44 Skilled Nursing Facility												44
45 Nursing Facilty												45
46 Other Long Term Care												46
ANCILLARY SERVICE COST CENTERS												
50 Operating Room	46,009,488		46,009,488		46,009,488	102,001,560	107,193,256	209,194,816	** 0.219936	** 0.219936	** 0.219936	50
51 Recovery Room	3,671,692		3,671,692		3,671,692	6,744,618	10,349,471	17,094,088	** 0.214793	** 0.214793	** 0.214793	51
52 Labor Room and Delivery Room	2,762,117		2,762,117		2,762,117	4,547,016	396,522	4,943,538	** 0.558733	** 0.558733	** 0.558733	52
53 Anesthesiology												53
54 Radiology-Diagnostic	21,278,684		21,278,684		21,278,684	17,671,376	97,607,216	115,278,592	** 0.184585	** 0.184585	** 0.184585	54
55 Radiology-Therapeutic	11,787,547		11,787,547		11,787,547	2,426,879	53,080,520	55,507,396	** 0.212360	** 0.212360	** 0.212360	55
56 Radioisotope												56
57 Computed Tomography (CT) Scan	1,878,288		1,878,288		1,878,288	10,786,547	27,490,636	38,277,184	** 0.049071	** 0.049071	** 0.049071	57
58 Magnetic Resonance Imaging (MRI)	963,004		963,004		963,004	4,347,122	11,635,999	15,983,121	** 0.060251	** 0.060251	** 0.060251	58
59 Cardiac Catheterization	7,632,043		7,632,043		7,632,043	28,744,544	34,017,436	62,761,980	** 0.121603	** 0.121603	** 0.121603	59
60 Laboratory	15,559,772		15,559,772		15,559,772	77,843,456	54,541,328	132,384,784	** 0.117534	** 0.117534	** 0.117534	60
60.45 Vascular Lab	3,650,951		3,650,951		3,650,951	4,967,103	12,311,588	17,278,692	** 0.211298	** 0.211298	** 0.211298	60.45
61 PBP Clinical Laboratory Services-Prgm. Only												61
62 Whole Blood & Packed Red Blood Cells												62
63 Blood Storing, Processing, & Trans.	4,228,044		4,228,044		4,228,044	16,112,581	2,314,708	18,427,288	** 0.229445	** 0.229445	** 0.229445	63
64 Intravenous Therapy												64
65 Respiratory Therapy	4,780,549		4,780,549		4,780,549	10,130,227	3,698,808	13,829,035	** 0.345689	** 0.345689	** 0.345689	65

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COMPUTATION OF RATIO OF COSTS TO CHARGES						Provider CCN: 420087			PERIOD: FROM 01/01/2011 TO 12/31/2011		WORKSHEET C PART I	
COST CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
			Total Costs	RCE Dis-allowance	Total Costs	Inpatient	Outpatient	Total (column 6 + column 7)				
	1	2	3	4	5	6	7	8	9	10	11	
66 Physical Therapy	6,887,874		6,887,874		6,887,874	24,168,304	4,635,015	28,803,318	** 0.239135	** 0.239135	** 0.239135	66
67 Occupational Therapy												67
68 Speech Pathology												68
69 Electrocardiology	1,844,102		1,844,102		1,844,102	9,824,070	6,012,933	15,837,003	** 0.116443	** 0.116443	** 0.116443	69
70 Electroencephalography												70
71 Medical Supplies Charged to Patients												71
72 Implantable Devices Charged to Patients	30,648,124		30,648,124		30,648,124	43,421,268	28,336,636	71,757,904	** 0.427105	** 0.427105	** 0.427105	72
73 Drugs Charged to Patients	28,745,324		28,745,324		28,745,324	65,972,808	29,284,030	95,256,840	** 0.301767	** 0.301767	** 0.301767	73
74 Renal Dialysis												74
75 ASC (Non-Distinct Part)												75
76 Other Ancillary (specify)												76
76 30 Other Ancillary Cost Centers	2,164,503		2,164,503		2,164,503	3,303,804	134,166	3,437,970	** 0.629588	** 0.629588	** 0.629588	76 30
OUTPATIENT SERVICE COST CENTERS												
88 Rural Health Clinic (RHC)												88
89 Federally Qualified Health Center (FQHC)												89
90 Clinic												90
91 Emergency	16,113,242		16,113,242		16,113,242	23,674,620	91,727,888	115,402,504	** 0.139626	** 0.139626	** 0.139626	91
92 Observation Beds (see instructions)	2,315,192		2,315,192		2,315,192		3,201,241	3,201,241	** 0.723217	** 0.723217	** 0.723217	92
93 Other Outpatient Service (specify)												93
OTHER REIMBURSABLE COST CENTERS												
94 Home Program Dialysis												94
95 Ambulance Services	3,037,545		3,037,545		3,037,545	1,913,305	3,345,017	5,258,322	** 0.577664	** 0.577664	** 0.577664	95
96 Durable Medical Equipment-Rented												96
97 Durable Medical Equipment-Sold												97
98 Other Reimbursable (specify)												98
99 Outpatient Rehabilitation Provider (specify)												99
100 Intern-Resident Service (not appvd. tchng. prgm.)												100
101 Home Health Agency	9,619,159		9,619,159		9,619,159		8,155,632	8,155,632				101
SPECIAL PURPOSE COST CENTERS												
105 Kidney Acquisition												105
106 Heart Acquisition												106
107 Liver Acquisition												107
108 Lung Acquisition												108
109 Pancreas Acquisition												109
110 Intestinal Acquisition												110

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COMPUTATION OF RATIO OF COSTS TO CHARGES						Provider CCN: 420087			PERIOD: FROM 01/01/2011 TO 12/31/2011		WORKSHEET C PART I	
COST CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
			Total Costs	RCE Dis-allowance	Total Costs	Inpatient	Outpatient	Total (column 6 + column 7)				
	1	2	3	4	5	6	7	8	9	10	11	
111 Islet Acquisition												111
112 Other Organ Acquisition (specify)												112
115 Ambulatory Surgical Center (Distinct Part)												115
116 Hospice												116
117 Other Special Purpose (specify)												117
200 Subtotal (see instructions)	320,952,928		320,952,928		320,952,928	610,518,784	589,470,016	1,199,988,864				200
201 Less Observation Beds	2,315,192		2,315,192		2,315,192							201
202 Total (see instructions)	318,637,760		318,637,760		318,637,760	610,518,784	589,470,016	1,199,988,864				202
FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTIONS 4023)												
40-564 - 08-11											Rev. 2	

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ROPER HOSPITAL - CHARLESTON, SC
Cost report status - As Submitted
[Record code 7200 - 2010]

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS	Provider CCN: 420087	PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET D, PART I

Medicare - Title XVIII - Hospital

		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics (General Routine Care)	8,698,198		8,698,198	61,864	140.60	32,728	4,601,557	30
31	Intensive Care Unit	1,815,293		1,815,293	8,434	215.24	4,809	1,035,089	31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care Unit (specify)								35
40	Subprovider IPF								40
41	Subprovider IRF	1,478,000		1,478,000	15,221	97.10	10,383	1,008,189	41
42	Subprovider (Other)								42
43	Nursery	111,343		111,343	1,678	66.35			43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	12,102,834		12,102,834	87,197		47,920	6,644,835	200

(A) Worksheet A line numbers

FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTIONS 4024 - 4024.1)

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ROPER HOSPITAL - CHARLESTON, SC
Cost report status - As Submitted
[Record code 7200 - 2010]

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 420087	PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET D, PART II

Medicare -Title XVIII - Hospital

		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)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	6,739,869	209,194,816	** 0.032218	47,155,556	1,519,258	50
51	Recovery Room	307,242	17,094,088	** 0.017974	3,195,470	57,435	51
52	Labor Room and Delivery Room	450,297	4,943,538	** 0.091088	9,171	835	52
53	Anesthesiology						53
54	Radiology-Diagnostic	4,004,693	115,278,592	** 0.034739	11,330,453	393,609	54
55	Radiology-Therapeutic	3,313,083	55,507,396	** 0.059687	1,110,852	66,303	55
56	Radioisotope						56
57	Computed Tomography (CT) Scan	514,126	38,277,184	** 0.013432	8,645,131	116,121	57
58	Magnetic Resonance Imaging (MRI)	203,759	15,983,121	** 0.012748	2,259,307	28,802	58
59	Cardiac Catheterization	1,616,262	62,761,980	** 0.025752	14,576,564	375,376	60
60	Laboratory	1,308,752	132,384,784	** 0.009886	42,310,120	418,278	60
60.45		851,928	17,278,692	** 0.049305	2,033,494	100,261	60.45
61	PBP Clinical Laboratory Services-Prgm. Only						61
62	Whole Blood & Packed Red Blood Cells						62
63	Blood Storing, Processing, & Transfusing	165,318	18,427,288	** 0.008971	8,197,335	73,538	63
64	Intravenous Therapy						64
65	Respiratory Therapy	405,136	13,829,035	** 0.029296	5,841,752	171,140	65
66	Physical Therapy	531,623	28,803,318	** 0.018457	3,484,959	64,322	66
67	Occupational Therapy						67
68	Speech Pathology						68
69	Electrocardiology	566,190	15,837,003	** 0.035751	6,294,025	225,018	69
70	Electroencephalography						70
71	Medical Supplies Charged to Patients						71
72	Implantable Devices Charged to Patients	175,468	71,757,904	** 0.002445	23,885,564	58,400	72
73	Drugs Charged to Patients	732,127	95,256,840	** 0.007686	31,195,768	239,771	73
74	Renal Dialysis						74
75	ASC (Non-Distinct Part)						75
76	Other Ancillary (specify)						76
76.30		190,617	3,437,970	** 0.055445	2,157,157	118,929	76.30
88	Rural Health Clinic (RHC)						88
89	Federally Qualified Health Center (FQHC)						89
90	Clinic						90
91	Emergency	1,468,089	115,402,504	** 0.012721	13,096,432	166,600	91
92	Observation Beds	306,230	3,201,241	** 0.095660			92
93	Other Outpatient Service (specify)						93
	OTHER REIMBURSABLE COST CENTERS						
94	Home Program Dialysis						94
95	Ambulance Services						95
96	Durable Medical Equipment-Rented						96
97	Durable Medical Equipment-Sold						97
98	Other Reimbursable (specify)						98
200	Total (sum of lines 50 through 199)	23,850,808	1,034,657,280	** 0.023052	226,779,104	4,193,996	200

(A) Worksheet A line numbers

FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4024.2)

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ROPER HOSPITAL - CHARLESTON, SC
Cost report status - As Submitted
[Record code 7200 - 2010]

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 420087	PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET D, PART II

Medicare -Title XVIII - SNF

		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)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	6,739,869	209,194,816	** 0.032218	82,691	2,664	50
51	Recovery Room	307,242	17,094,088	** 0.017974	10,323	186	51
52	Labor Room and Delivery Room	450,297	4,943,538	** 0.091088			52
53	Anesthesiology						53
54	Radiology-Diagnostic	4,004,693	115,278,592	** 0.034739	478,896	16,636	54
55	Radiology-Therapeutic	3,313,083	55,507,396	** 0.059687	45,471	2,714	55
56	Radioisotope						56
57	Computed Tomography (CT) Scan	514,126	38,277,184	** 0.013432	269,809	3,624	57
58	Magnetic Resonance Imaging (MRI)	203,759	15,983,121	** 0.012748	126,468	1,612	58
59	Cardiac Catheterization	1,616,262	62,761,980	** 0.025752	26,519	683	60
60	Laboratory	1,308,752	132,384,784	** 0.009886	2,772,024	27,404	60
60.45		851,928	17,278,692	** 0.049305	1,091,035	53,793	60.45
61	PBP Clinical Laboratory Services-Prgm. Only						61
62	Whole Blood & Packed Red Blood Cells						62
63	Blood Storing, Processing, & Transfusing	165,318	18,427,288	** 0.008971	189,177	1,697	63
64	Intravenous Therapy						64
65	Respiratory Therapy	405,136	13,829,035	** 0.029296	283,018	8,291	65
66	Physical Therapy	531,623	28,803,318	** 0.018457	12,614,512	232,826	66
67	Occupational Therapy						67
68	Speech Pathology						68
69	Electrocardiology	566,190	15,837,003	** 0.035751	100,123	3,579	69
70	Electroencephalography						70
71	Medical Supplies Charged to Patients						71
72	Implantable Devices Charged to Patients	175,468	71,757,904	** 0.002445	45,901	112	72
73	Drugs Charged to Patients	732,127	95,256,840	** 0.007686	2,621,839	20,151	73
74	Renal Dialysis						74
75	ASC (Non-Distinct Part)						75
76	Other Ancillary (specify)						76
76.30		190,617	3,437,970	** 0.055445	138,140	7,732	76.30
88	Rural Health Clinic (RHC)						88
89	Federally Qualified Health Center (FQHC)						89
90	Clinic						90
91	Emergency	1,468,089	115,402,504	** 0.012721	16,147	205	91
92	Observation Beds	306,230	3,201,241	** 0.095660			92
93	Other Outpatient Service (specify)						93
	OTHER REIMBURSABLE COST CENTERS						
94	Home Program Dialysis						94
95	Ambulance Services						95
96	Durable Medical Equipment-Rented						96
97	Durable Medical Equipment-Sold						97
98	Other Reimbursable (specify)						98
200	Total (sum of lines 50 through 199)	23,850,808	1,034,657,280	** 0.023052	20,912,092	383,909	200

(A) Worksheet A line numbers

FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4024.2)

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Cost report status - As Submitted
[Record code 7200 - 2010]

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 420087	PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET D, PART III

Medicare - Title XVIII - Hospital

		Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	1	2	3	4	5	6	7	8	9	
INPATIENT ROUTINE SERVICE COST CENTERS											
30	Adults & Pediatrics (General Routine Care)		167,268			167,268	61,864	2.70	32,728	88,366	30
31	Intensive Care Unit		61,993			61,993	8,434	7.35	4,809	35,346	31
32	Coronary Care Unit										32
33	Burn Intensive Care Unit										33
34	Surgical Intensive Care Unit										34
35	Other Special Care Unit (specify)										35
40	Subprovider IPF										40
41	Subprovider IRF		18,484			18,484	15,221	1.21	10,383	12,563	41
42	Subprovider (Other)										42
43	Nursery						1,678				43
44	Skilled Nursing Facility										44
45	Nursing Facility										45
200	Total (sum of lines 30-199)		247,745			247,745	87,197		47,920	136,275	200

(A) Worksheet A line numbers

FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4024.3)

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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 420087	PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET D, PART IV

Medicare -Title XVIII - Hospital

		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total cost (sum of col 1 through col. 4)	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	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	1	2	3	4	5	6	7	8	9	10	11	12	13	
ANCILLARY SERVICE COST CENTERS															
50	Operating Room			31,111		31,111	31,111	209,194,816			47,155,556	7,026	25,426,880	3,789	50
51	Recovery Room			4,031		4,031	4,031	17,094,088			3,195,470	754	3,095,528	731	51
52	Labor room and Delivery Room			4,108		4,108	4,108	4,943,538			9,171	8	6,817	6	52
53	Anesthesiology														53
54	Radiology-Diagnostic							115,278,592			11,330,453		34,585,304		54
55	Radiology-Therapeutic			2,130		2,130	2,130	55,507,396			1,110,852	42	23,450,468	891	55
56	Radioisotope														56
57	Computed Tomography (CT) Scan							38,277,184			8,645,131		8,154,652		57
58	Magnetic Resonance Imaging (MRI)							15,983,121			2,259,307		3,718,094		58
59	Cardiac Catheterization							62,761,980			14,576,564		16,604,277		59
60	Laboratory							132,384,784			42,310,120		17,972,620		60
60.45	Vascular Lab							17,278,692			2,033,494		6,697,039		60.45
61	PBP Clinical Laboratory Services-Prgm. Only														61
62	Whole Blood & Packed Red Blood Cells														62
63	Blood Storing, Processing, & Transfusing							18,427,288			8,197,335		919,543		63
64	Intravenous Therapy														64
65	Respiratory Therapy							13,829,035			5,841,752		1,125,218		65
66	Physical Therapy							28,803,318			3,484,959		1,549,638		66
67	Occupational Therapy														67
68	Speech Pathology														68
69	Electrocardiology							15,837,003			6,294,025		2,455,533		69
70	Electroencephalography														70
71	Medical Supplies Charged To Patients														71
72	Implantable Devices Charged to Patients							71,757,904			23,885,564		16,880,500		72
73	Drugs Charged to Patients							95,256,840			31,195,768		10,947,323		73
74	Renal Dialysis														74
75	ASC (Non-Distinct Part)														75
76	Other Ancillary (specify)														76
76.30	Other Ancillary Cost Centers							3,437,970			2,157,157		85,274		76.30
OUTPATIENT SERVICE COST CENTERS															

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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS										Provider CCN: 420087	PERIOD: FROM 01/01/2011 TO 12/31/2011			WORKSHEET D, PART IV	
Medicare - Title XVIII - Hospital															
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total cost (sum of col 1 through col. 4)	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	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	1	2	3	4	5	6	7	8	9	10	11	12	13	
88	Rural Health Clinic (RHC)														88
89	Federally Qualified Health Center (FQHC)														89
90	Clinic														90
91	Emergency			9,965		9,965	9,965	115,402,504			13,096,432	1,126	17,294,188	1,487	91
92	Observation Beds			5,890		5,890	5,890	3,201,241					1,498,949	2,758	92
93	Other Outpatient Service (specify)														93
OTHER REIMBURSABLE COST CENTERS															
94	Home Program Dialysis														94
95	Ambulance Services														95
96	Durable Medical Equipment-Rented														96
97	Durable Medical Equipment-Sold														97
98	Other Reimbursable (specify)														98
200	Total (sum of lines 50 through 199)			57,235		57,235	57,235	1,034,657,280			226,779,104	8,956	192,467,840	9,662	200
(A) Worksheet A line numbers															
FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4024.4)															
Rev. 2 - 08-11														40-571	

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ROPER HOSPITAL - CHARLESTON, SC
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 420087	PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET D, PART IV

Medicare -Title XVIII - SNF

		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total cost (sum of col 1 through col. 4)	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	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	1	2	3	4	5	6	7	8	9	10	11	12	13	
ANCILLARY SERVICE COST CENTERS															
50	Operating Room			31,111		31,111	31,111	209,194,816			82,691	12			50
51	Recovery Room			4,031		4,031	4,031	17,094,088			10,323	2			51
52	Labor room and Delivery Room			4,108		4,108	4,108	4,943,538							52
53	Anesthesiology														53
54	Radiology-Diagnostic							115,278,592			478,896		2,474		54
55	Radiology-Therapeutic			2,130		2,130	2,130	55,507,396			45,471	2			55
56	Radioisotope														56
57	Computed Tomography (CT) Scan							38,277,184			269,809		3,322		57
58	Magnetic Resonance Imaging (MRI)							15,983,121			126,468				58
59	Cardiac Catheterization							62,761,980			26,519				59
60	Laboratory							132,384,784			2,772,024		18,818		60
60.45	Vascular Lab							17,278,692			1,091,035		3,444		60.45
61	PBP Clinical Laboratory Services-Prgm. Only														61
62	Whole Blood & Packed Red Blood Cells														62
63	Blood Storing, Processing, & Transfusing							18,427,288			189,177				63
64	Intravenous Therapy														64
65	Respiratory Therapy							13,829,035			283,018				65
66	Physical Therapy							28,803,318			12,614,512		56,498		66
67	Occupational Therapy														67
68	Speech Pathology														68
69	Electrocardiology							15,837,003			100,123				69
70	Electroencephalography														70
71	Medical Supplies Charged To Patients														71
72	Implantable Devices Charged to Patients							71,757,904			45,901				72
73	Drugs Charged to Patients							95,256,840			2,621,839		4,979		73
74	Renal Dialysis														74
75	ASC (Non-Distinct Part)														75
76	Other Ancillary (specify)														76
76 30	Other Ancillary Cost Centers							3,437,970			138,140				76 30
OUTPATIENT SERVICE COST CENTERS															

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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS										Provider CCN: 420087	PERIOD: FROM 01/01/2011 TO 12/31/2011			WORKSHEET D, PART IV	
Medicare -Title XVIII - SNF															
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part 1, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	1	2	3	4	5	6	7	8	9	10	11	12	13	
88	Rural Health Clinic (RHC)														88
89	Federally Qualified Health Center (FQHC)														89
90	Clinic														90
91	Emergency			9,965		9,965	9,965	115,402,504			16,147	1			91
92	Observation Beds			5,890		5,890	5,890	3,201,241							92
93	Other Outpatient Service (specify)														93
OTHER REIMBURSABLE COST CENTERS															
94	Home Program Dialysis														94
95	Ambulance Services														95
96	Durable Medical Equipment-Rented														96
97	Durable Medical Equipment-Sold														97
98	Other Reimbursable (specify)														98
200	Total (sum of lines 50 through 199)			57,235		57,235	57,235	1,034,657,280			20,912,092	17	89,535		200
(A) Worksheet A line numbers															
FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4024.4)															
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ROPER HOSPITAL - CHARLESTON, SC
Cost report status - As Submitted
[Record code 7200 - 2010]

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS	Provider CCN: 420087	PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET D, PART V

Medicare - Title XVIII - SNF

PART V - APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

		Cost to Charge Ratio from Worksheet C, Part I, col. 9	Program Charges			Program Cost			
			PPS Reimbursed Services (see instructions)	Cost Reimbursed Services Subject to Ded. & Coins. (see instructions)	Cost Reimbursed Services Not Subject to Ded. & Coins. (see instructions)	PPS Services (see instructions)	Cost Services Subject to Ded. & Coins. (see instructions)	Cost Services Not Subject to Ded. & Coins. (see instructions)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
ANCILLARY SERVICE COST CENTERS									
50	Operating Room								50
51	Recovery Room								51
52	Labor & Delivery Room								52
53	Anesthesiology								53
54	Radiology-Diagnostic		2,474			457			54
55	Radiology-Therapeutic								55
56	Radioisotope								56
57	Computed Tomography (CT) Scan		3,322			163			57
58	Magnetic Resonance Imaging (MRI)								58
59	Cardiac Catheterization								59
60	Laboratory		18,818			2,212			60
60.45	Vascular Lab		3,444			728			60.45
61	PBP Clinic Laboratory Services-Prgm. Only								61
62	Whole Blood & Packed Red Blood Cells								62
63	Blood Storing, Processing, & Transfusing								63
64	Intravenous Therapy								64
65	Respiratory Therapy								65
66	Physical Therapy		56,498			13,511			66
67	Occupational Therapy								67
68	Speech Pathology								68
69	Electrocardiology								69
70	Electroencephalography								70
71	Medical Supplies Charged To Patients								71
72	Implantable Devices Charged to Patients								72
73	Drugs Charged to Patients		4,979			1,502			73
74	Renal Dialysis								74
75	ASC (Non-Distinct Part)								75
76	Other Ancillary (specify)								76
OUTPATIENT SERVICE COST CENTERS									
88	Rural Health Clinic (RHC)								88
89	Federally Qualified Health Center (FQHC)								89
90	Clinic								90
91	Emergency								91
92	Observation Bed								92
93	Other Outpatient Service (specify)								93
OTHER REIMBURSABLE COST CENTERS									
94	Home Program Dialysis								94
95	Ambulance								95
96	Durable Medical Equipment-Rented								96
97	Durable Medical Equipment-Sold								97
98	Other Reimbursable Cost Center								98
200	Subtotal (see instructions)		89,535			18,573			200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		89,535			18,573			202

FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTIONS 4024.5)

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ROPER HOSPITAL - CHARLESTON, SC
Cost report status - As Submitted
[Record code 7200 - 2010]

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS	Provider CCN: 420087	PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET D, PART V

Medicare -Title XVIII - Hospital

PART V - APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

		Cost to Charge Ratio from Worksheet C, Part I, col. 9	Program Charges			Program Cost			
			PPS Reimbursed Services (see instructions)	Cost Reimbursed Services Subject to Ded. & Coins. (see instructions)	Cost Reimbursed Services Not Subject to Ded. & Coins. (see instructions)	PPS Services (see instructions)	Cost Services Subject to Ded. & Coins. (see instructions)	Cost Services Not Subject to Ded. & Coins. (see instructions)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
ANCILLARY SERVICE COST CENTERS									
50	Operating Room		25,426,880			5,592,286			50
51	Recovery Room		3,095,528			664,898			51
52	Labor & Delivery Room		6,817			3,809			52
53	Anesthesiology								53
54	Radiology-Diagnostic		34,585,304			6,383,928			54
55	Radiology-Therapeutic		23,450,468			4,979,941			55
56	Radioisotope								56
57	Computed Tomography (CT) Scan		8,154,652			400,157			57
58	Magnetic Resonance Imaging (MRI)		3,718,094			224,019			58
59	Cardiac Catheterization		16,604,277			2,019,130			59
60	Laboratory		17,972,620			2,112,394			60
60.45	Vascular Lab		6,697,039			1,415,071			60.45
61	PBP Clinic Laboratory Services-Prgm. Only								61
62	Whole Blood & Packed Red Blood Cells								62
63	Blood Storing, Processing, & Transfusing		919,543			210,985			63
64	Intravenous Therapy								64
65	Respiratory Therapy		1,125,218			388,975			65
66	Physical Therapy		1,549,638			370,573			66
67	Occupational Therapy								67
68	Speech Pathology								68
69	Electrocardiology		2,455,533			285,930			69
70	Electroencephalography								70
71	Medical Supplies Charged To Patients								71
72	Implantable Devices Charged to Patients		16,880,500			7,209,746			72
73	Drugs Charged to Patients		10,947,323			3,303,541			73
74	Renal Dialysis								74
75	ASC (Non-Distinct Part)								75
76	Other Ancillary (specify)								76
76.30	Other Ancillary Cost Centers		85,274			54,050			76.30
OUTPATIENT SERVICE COST CENTERS									
88	Rural Health Clinic (RHC)								88
89	Federally Qualified Health Center (FQHC)								89
90	Clinic								90
91	Emergency		17,294,188			2,414,718			91
92	Observation Bed		1,498,949			1,084,065			92
93	Other Outpatient Service (specify)								93
OTHER REIMBURSABLE COST CENTERS									
94	Home Program Dialysis								94
95	Ambulance								95
96	Durable Medical Equipment-Rented								96
97	Durable Medical Equipment-Sold								97
98	Other Reimbursable Cost Center								98
200	Subtotal (see instructions)		192,467,840			39,118,216			200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		192,467,840			39,118,216			202

FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTIONS 4024.5)

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COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 420087	PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET D-1, PART I

Medicare -Title XVIII - SNF

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	Inpatient days (including private room days and swing-bed days, excluding newborn)	15,221	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	15,221	2
3	Private room days (excluding swing-bed and observation bed days)		3
4	Semi-private room days (excluding swing-bed and observation bed days)	15,221	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	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)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	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)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	10,383	9
10	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).		10
11	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)		11
12	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.		12
13	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)		13
14	Medically necessary private room days applicable to the Program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16
	SWING BED ADJUSTMENT		
17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	12,628,898	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	12,628,898	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	General inpatient routine service charges (excluding swing-bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	12,628,898	37

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COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 420087	PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET D-1, PART I

Medicare -Title XVIII - Hospital

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	Inpatient days (including private room days and swing-bed days, excluding newborn)	61,864	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	61,864	2
3	Private room days (excluding swing-bed and observation bed days)		3
4	Semi-private room days (excluding swing-bed and observation bed days)	61,864	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	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)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	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)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	32,728	9
10	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).		10
11	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)		11
12	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.		12
13	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)		13
14	Medically necessary private room days applicable to the Program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16
	SWING BED ADJUSTMENT		
17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	65,761,036	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	65,761,036	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	General inpatient routine service charges (excluding swing-bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	65,761,036	37

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COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 420087	PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET D-1, PART II

Medicare -Title XVIII - SNF

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS					1		
38	Adjusted general inpatient routine service cost per diem (see instructions)				829	38	
39	Program general inpatient routine service cost (line 9 x line 38)				8,614,775	39	
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)					40	
41	Total Program general inpatient routine service cost (line 39 + line 40)				8,614,775	41	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1	2	3	4	5	
42	Nursery (title V & XIX only) Intensive Care Type Inpatient Hospital Units						42
43	Intensive Care Unit						43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care Unit (specify)						47
						1	
48	Program inpatient ancillary service cost (Worksheet D-3, column 3, line 200)					4,768,958	48
49	Total Program inpatient costs (sum of lines 41 through 48) (see instructions)					13,383,733	49
PASS-THROUGH COST ADJUSTMENTS							
50	Pass through costs applicable to Program inpatient routine services (from Worksheet D, sum of Parts I and III)					1,020,752	50
51	Pass through costs applicable to Program inpatient ancillary services (from Worksheet D, sum of Parts II and IV)					383,926	51
52	Total Program excludable cost (sum of lines 50 and 51)					1,404,678	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist, and medical education costs (line 49 minus line 52)					11,979,055	53
TARGET AMOUNT AND LIMIT COMPUTATION							
54	Program discharges						54
55	Target amount per discharge						55
56	Target amount (line 54 x line 55)						56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57
58	Bonus payment (see instructions)						58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket						59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket						60
61	If line 53 ÷ line 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)						61
62	Relief payment (see instructions)						62
63	Allowable Inpatient cost plus incentive payment (see instructions)						63
PROGRAM INPATIENT ROUTINE SWING BED COST							
64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (see instructions) (title XVIII only)						64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (see instructions) (title XVIII only)						65
66	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (Title XVIII only. For CAH, see instructions.)						66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69

FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4025.2)

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COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 420087	PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET D-1, PART II

Medicare -Title XVIII - Hospital

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS					1		
38	Adjusted general inpatient routine service cost per diem (see instructions)				1,062		38
39	Program general inpatient routine service cost (line 9 x line 38)				34,789,536		39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)						40
41	Total Program general inpatient routine service cost (line 39 + line 40)				34,789,536		41
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1	2	3	4	5	
42	Nursery (title V & XIX only) Intensive Care Type Inpatient Hospital Units						42
43	Intensive Care Unit	15,223,558	8,434	** 1,805.02	4,809	8,680,341	43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care Unit (specify)						47
						1	
48	Program inpatient ancillary service cost (Worksheet D-3, column 3, line 200)					49,388,788	48
49	Total Program inpatient costs (sum of lines 41 through 48) (see instructions)					92,858,664	49
PASS-THROUGH COST ADJUSTMENTS							
50	Pass through costs applicable to Program inpatient routine services (from Worksheet D, sum of Parts I and III)					5,760,358	50
51	Pass through costs applicable to Program inpatient ancillary services (from Worksheet D, sum of Parts II and IV)					4,202,952	51
52	Total Program excludable cost (sum of lines 50 and 51)					9,963,310	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist, and medical education costs (line 49 minus line 52)					82,895,360	53
TARGET AMOUNT AND LIMIT COMPUTATION							
54	Program discharges						54
55	Target amount per discharge						55
56	Target amount (line 54 x line 55)						56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57
58	Bonus payment (see instructions)						58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket						59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket						60
61	If line 53 ÷ line 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)						61
62	Relief payment (see instructions)						62
63	Allowable Inpatient cost plus incentive payment (see instructions)						63
PROGRAM INPATIENT ROUTINE SWING BED COST							
64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (see instructions) (title XVIII only)						64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (see instructions) (title XVIII only)						65
66	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (Title XVIII only. For CAH, see instructions.)						66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69

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COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 420087	PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET D-1, PARTS III & IV

Medicare -Title XVIII - Hospital

PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY. AND ICT/MR ONLY

70	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)		70
71	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71
72	Program routine service cost (line 9 x line 71)		72
73	Medically necessary private room cost applicable to Program (line 14 x line 35)		73
74	Total Program general inpatient routine service costs (line 72 + line 73)		74
75	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Parts II, column 26, line 45)		75
76	Per diem capital-related costs (line 75 ÷ line 2)		76
77	Program capital-related costs (line 9 x line 76)		77
78	Inpatient routine service cost (line 74 minus line 77)		78
79	Aggregate charges to beneficiaries for excess costs (from provider records)		79
80	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80
81	Inpatient routine service cost per diem limitation		81
82	Inpatient routine service cost limitation (line 9 x line 81)		82
83	Reasonable inpatient routine service costs (see instructions)		83
84	Program inpatient ancillary services (see instructions)		84
85	Utilization review - physician compensation (see instructions)		85
86	Total Program inpatient operating costs (sum of lines 83 through 85)		86

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)	2,178	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,062.99	88
89	Observation bed cost (line 87 x line 88) (see instructions)	2,315,192	89

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

		Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass-Through Cost (col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost	8,698,198	65,761,036	0.132270	2,315,192	306,230	90
91	Nursing School cost		65,761,036		2,315,192		91
92	Allied Health cost	167,268	65,761,036	0.002544	2,315,192	5,890	92
93	All other Medical Education		65,761,036		2,315,192		93

FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTIONS 4025.3 - 4025.4)

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ROPER HOSPITAL - CHARLESTON, SC
Cost report status - As Submitted
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COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 420087	PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET D-1, PARTS III & IV

Medicare -Title XVIII - SNF

PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY. AND ICT/MR ONLY

70	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)		70
71	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71
72	Program routine service cost (line 9 x line 71)		72
73	Medically necessary private room cost applicable to Program (line 14 x line 35)		73
74	Total Program general inpatient routine service costs (line 72 + line 73)		74
75	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Parts II, column 26, line 45)		75
76	Per diem capital-related costs (line 75 ÷ line 2)		76
77	Program capital-related costs (line 9 x line 76)		77
78	Inpatient routine service cost (line 74 minus line 77)		78
79	Aggregate charges to beneficiaries for excess costs (from provider records)		79
80	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80
81	Inpatient routine service cost per diem limitation		81
82	Inpatient routine service cost limitation (line 9 x line 81)		82
83	Reasonable inpatient routine service costs (see instructions)		83
84	Program inpatient ancillary services (see instructions)		84
85	Utilization review - physician compensation (see instructions)		85
86	Total Program inpatient operating costs (sum of lines 83 through 85)		86

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)		87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)		88
89	Observation bed cost (line 87 x line 88) (see instructions)		89

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

		Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass-Through Cost (col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost	1,478,000	12,628,898	0.117033			90
91	Nursing School cost		12,628,898				91
92	Allied Health cost	18,484	12,628,898	0.001464			92
93	All other Medical Education		12,628,898				93

FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTIONS 4025.3 - 4025.4)

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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 420087	PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET D-3

Medicare -Title XVIII - Hospital

	(A) COST CENTER DESCRIPTION	Ratio of Cost to Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults and Pediatrics (General Routine Care)		53,242,404		30
31	Intensive Care Unit		17,529,484		31
32	Coronary Care Unit				32
33	Burn Intensive Care Unit				33
34	Surgical Intensive Care Unit				34
35	Other Special Care (specify)				35
40	Subprovider IPF				40
41	Subprovider IRF				41
42	Subprovider (Specify)				42
43	Nursery				43
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room		47,155,556	10,371,205	50
51	Recovery Room		3,195,470	686,365	51
52	Labor Room and Delivery Room		9,171	5,124	52
53	Anesthesiology				53
54	Radiology-Diagnostic		11,330,453	2,091,432	54
55	Radiology-Therapeutic		1,110,852	235,901	55
56	Radioisotope				56
57	Computed Tomography (CT) Scan		8,645,131	424,225	57
58	Magnetic Resonance Imaging (MRI)		2,259,307	136,126	58
59	Cardiac Catheterization		14,576,564	1,772,554	59
60	Laboratory		42,310,120	4,972,878	60
61	PBP Clinical Laboratory Services-Prgm. Only				61
62	Whole Blood & Packed Red Blood Cells				62
63	Blood Storing, Processing, & Trans.		8,197,335	1,880,838	63
64	Intravenous Therapy				64
65	Respiratory Therapy		5,841,752	2,019,429	65
66	Physical Therapy		3,484,959	833,376	66
67	Occupational Therapy				67
68	Speech Pathology				68
69	Electrocardiology		6,294,025	732,895	69
70	Electroencephalography				70
71	Medical Supplies Charged to Patients				71
72	Implantable Devices Charged to Patients		23,885,564	10,201,644	72
73	Drugs Charged to Patients		31,195,768	9,413,853	73
74	Renal Dialysis				74
75	ASC (Non-Distinct Part)				75
76	Other Ancillary (specify)		4,190,651	1,782,342	76
	OUTPATIENT SERVICE COST CENTERS				
88	Rural Health Clinic (RHC)				88
89	Federally Qualified Health Center (FQHC)				89
90	Clinic				90
91	Emergency		13,096,432	1,828,602	91
92	Observation Beds (see instructions)				92
93	Other Outpatient Service (specify)				93
	OTHER REIMBURSABLE COST CENTERS				
94	Home Program Dialysis				94
95	Ambulance Services				95
96	Durable Medical Equipment-Rented				96
97	Durable Medical Equipment-Sold				97
98	Other Reimbursable (specify)				98
200	Total (sum of lines 50-94 and 96-98)		226,779,104	49,388,788	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		226,779,104		202

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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN. 420087	PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET D-3
(A) Worksheet A line numbers			
FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4027)			
40-578 - 08-11			Rev. 2

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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 420087	PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET D-3

Medicare -Title XVIII - SNF

	(A) COST CENTER DESCRIPTION	Ratio of Cost to Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults and Pediatrics (General Routine Care)				30
31	Intensive Care Unit				31
32	Coronary Care Unit				32
33	Burn Intensive Care Unit				33
34	Surgical Intensive Care Unit				34
35	Other Special Care (specify)				35
40	Subprovider IPF				40
41	Subprovider IRF		15,279,519		41
42	Subprovider (Specify)				42
43	Nursery				43
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room		82,691	18,187	50
51	Recovery Room		10,323	2,217	51
52	Labor Room and Delivery Room				52
53	Anesthesiology				53
54	Radiology-Diagnostic		478,896	88,397	54
55	Radiology-Therapeutic		45,471	9,656	55
56	Radioisotope				56
57	Computed Tomography (CT) Scan		269,809	13,240	57
58	Magnetic Resonance Imaging (MRI)		126,468	7,620	58
59	Cardiac Catheterization		26,519	3,225	59
60	Laboratory		2,772,024	325,807	60
61	PBP Clinical Laboratory Services-Prgm. Only				61
62	Whole Blood & Packed Red Blood Cells				62
63	Blood Storing, Processing, & Trans.		189,177	43,406	63
64	Intravenous Therapy				64
65	Respiratory Therapy		283,018	97,836	65
66	Physical Therapy		12,614,512	3,016,571	66
67	Occupational Therapy				67
68	Speech Pathology				68
69	Electrocardiology		100,123	11,659	69
70	Electroencephalography				70
71	Medical Supplies Charged to Patients				71
72	Implantable Devices Charged to Patients		45,901	19,605	72
73	Drugs Charged to Patients		2,621,839	791,184	73
74	Renal Dialysis				74
75	ASC (Non-Distinct Part)				75
76	Other Ancillary (specify)		1,229,175	318,093	76
	OUTPATIENT SERVICE COST CENTERS				
88	Rural Health Clinic (RHC)				88
89	Federally Qualified Health Center (FQHC)				89
90	Clinic				90
91	Emergency		16,147	2,255	91
92	Observation Beds (see instructions)				92
93	Other Outpatient Service (specify)				93
	OTHER REIMBURSABLE COST CENTERS				
94	Home Program Dialysis				94
95	Ambulance Services				95
96	Durable Medical Equipment-Rented				96
97	Durable Medical Equipment-Sold				97
98	Other Reimbursable (specify)				98
200	Total (sum of lines 50-94 and 96-98)		20,912,092	4,768,958	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		20,912,092		202

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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 420087	PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET D-3
(A) Worksheet A line numbers			
FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4027)			
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CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 420087	PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET E, PART A	
Medicare -Title XVIII - Hospital				
PART A - INPATIENT HOSPITAL SERVICES UNDER PPS				
1	DRG amounts other than outlier payments		63,030,160	1
2	Outlier payments for discharges (see instructions)		2,810,537	2
3	Managed care simulated payments			3
4	Bed days available divided by number of days in the cost reporting period (see instructions) Indirect Medical Education Adjustment Calculation for Hospitals		310.03	4
5	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996 (see instructions)			5
6	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in in accordance with 42 CFR 413.79(e)			6
7	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)			7
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.			7.01
8	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 Federal Register, page 50069, August 1, 2002.			8
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.			8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)			8.02
9	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line 8 plus lines (8.01 and 8.02) (see instructions)			9
10	FTE count for allopathic and osteopathic programs in the current year from your records			10
11	FTE count for residents in dental and podiatric programs			11
12	Current year allowable FTE (see instructions)			12
13	Total allowable FTE count for the prior year			13
14	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.			14
15	Sum of lines 12 through 14 divided by 3			15
16	Adjustment for residents in initial years of the program			16
17	Adjustment for residents displaced by program or hospital closure			17
18	Adjusted rolling average FTE count			18
19	Current year resident to bed ratio (line 18 divided by line 4)			19
20	Prior year resident to bed ratio (see instructions)			20
21	Enter the lesser of lines 19 or 20 (see instructions)			21
22	IME payment adjustment (see instructions)			22
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).			23
24	IME FTE resident count over cap (see instructions)			24
25	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)			25
26	Resident to bed ratio (divide line 25 by line 4)			26
27	IME payments adjustment (see instructions)			27
28	IME Adjustment (see instructions)			28
29	Total IME payment (sum of lines 22 and 28)			29
Disproportionate Share Adjustment				
30	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		0.071800	30
31	Percentage of Medicaid patient days to total days reported on Worksheet S-2, Part I, line 24. (see instructions)		0.097700	31
32	Sum of lines 30 and 31		0.169500	32
33	Allowable disproportionate share percentage (see instructions)		0.037700	33
34	Disproportionate share adjustment (see instructions)		2,376,237	34
Additional payment for high percentage of ESRD beneficiary discharges				
40	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)			40
41	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685 (see instructions)			41
42	Divide line 41 by line 40 (if less than .10%, you do not qualify for adjustment)			42
43	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685 (see instructions)			43
44	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)			44
45	Average weekly cost for dialysis treatments (see instructions)			45
46	Total additional payment (line 45 times line 44 times line 41)			46
47	Subtotal (see instructions)		68,216,936	47
48	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only (see instructions)			48
49	Total payment for inpatient operating costs SCH and MDH only (see instructions)		68,216,936	49

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CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 420087	PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET E, PART A	
Medicare -Title XVIII - Hospital				
50	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)	5,626,093		50
51	Exception payment for inpatient program capital (Worksheet L, Part III) (see instructions)			51
52	Direct graduate medical education payment (from Worksheet E-4, line 49) (see instructions).			52
53	Nursing and allied health managed care payment			53
54	Special add-on payments for new technologies			54
55	Net organ acquisition cost (Worksheet D-4 Part III, col. 1, line 69)			55
56	Cost of teaching physicians (Worksheet D-5, Part II, col. 3, line 20)			56
57	Routine service other pass through costs	123,712		57
58	Ancillary service other pass through costs Worksheet D, Part IV, col. 11 line 200)	8,956		58
59	Total (sum of amounts on lines 49 through 58)	73,975,696		59
60	Primary payer payments	43,135		60
61	Total amount payable for program beneficiaries (line 59 minus line 60)	73,932,560		61
62	Deductibles billed to program beneficiaries	5,844,240		62
63	Coinsurance billed to program beneficiaries	300,079		63
64	Allowable bad debts (see instructions)	232,713		64
65	Adjusted reimbursable bad debts (see instructions)	162,899		65
66	Allowable bad debts for dual eligible beneficiaries (see instructions)	97,555		66
67	Subtotal (line 61 plus line 65 minus lines 62 and 63)	67,951,144		67
68	Credits received from manufacturers for replaced devices applicable to MS-DRG (see instructions)			68
69	Outlier payments reconciliation			69
70	Other adjustments (specify) (see instructions)			70
71	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)	67,951,144		71
72	Interim payments	68,759,120		72
73	Tentative settlement (for contractor use only)			73
74	Balance due provider (Program) (lines 71 minus the sum of lines 72 and 73)	-807,982		74
75	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			75
TO BE COMPLETED BY CONTRACTOR				
90	Operating outlier amount from Worksheet E, Part A line 2	2,810,537		90
91	Capital outlier from Worksheet L, Part I, line 2	361,182		91
92	Operating outlier reconciliation adjustment amount (see instructions)			92
93	Capital outlier reconciliation adjustment amount (see instructions)			93
94	The rate used to calculate the Time Value of Money (see instructions)			94
95	Time Value of Money for operating expenses (see instructions)			95
96	Time Value of Money for capital related expenses (see instructions)			96
08-11				

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ROPER HOSPITAL - CHARLESTON, SC
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CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 420087	PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET E, PART B	
Medicare -Title XVIII - Hospital				
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1	Medical and other services (see instructions)			1
2	Medical and other services reimbursed under OPPS (see instructions).		39,108,552	2
3	PPS payments		36,453,644	3
4	Outlier payment (see instructions)			4
5	Enter the hospital specific payment to cost ratio (see instructions)			5
6	Line 2 times line 5			6
7	Sum of lines line 3 plus line 4 divided by line 6			7
8	Transitional corridor payment (see instructions)			8
9	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200		9,662	9
10	Organ acquisition			10
11	Total cost (sum of lines 1 and 10) (see instructions)			11
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable charges			
12	Ancillary service charges			12
13	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)			13
14	Total reasonable charges (sum of lines 12 and 13)			14
	Customary charges			
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis			15
16	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)			16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)			17
18	Total customary charges (see instructions)			18
19	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			20
21	Lesser of cost or charges (line 11 minus line 20) (for CAH, see instructions)			21
22	Interns and residents (see instructions)			22
23	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, §2148)			23
24	Total prospective payment (sum of lines 3, 4, 8 and 9)		36,463,304	24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
25	Deductibles and coinsurance (see instructions)			25
26	Deductibles and Coinsurance relating to amount on line 24 (see instructions)		7,535,122	26
27	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (see instructions)		28,928,184	27
28	Direct graduate medical education payments (from Worksheet E-4, line 50)			28
29	ESRD direct medical education costs (from Worksheet E-4, line 36)			29
30	Subtotal (sum of lines 27 through 29)		28,928,184	30
31	Primary payer payments		6,775	31
32	Subtotal (line 30 minus line 31)		28,921,408	32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)			
33	Composite rate ESRD (from Worksheet I-5, line 11)			33
34	Allowable bad debts (see instructions)		560,665	34
35	Adjusted reimbursable bad debts (see instructions)		392,466	35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)		433,541	36
37	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)		29,313,874	37
38	MSP-LCC reconciliation amount from PS&R			38
39	Other adjustments (specify) (see instructions)			39
40	Subtotal (line 37 plus or minus lines 39 minus 38)		29,313,874	40
41	Interim payments		29,473,638	41
42	Tentative settlement (for contractors use only)			42
43	Balance due provider/program (line 40 minus the sum of lines 41, and 42)		-159,764	43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			44
PART B - MEDICAL AND OTHER HEALTH SERVICES TO BE COMPLETED BY CONTRACTOR				
90	Original outlier amount (see instructions)			90
91	Outlier reconciliation adjustment amount (see instructions)			91
92	The rate used to calculate the Time Value of Money			92
93	Time Value of Money (see instructions)			93
94	Total (sum of lines 91 and 93)			94
FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4030.2)				

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CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 420087	PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET E, PART B
Medicare -Title XVIII - Hospital			
Rev. 2 - 08-11			40-587

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CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 420087	PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET E, PART B

Medicare -Title XVIII - SNF

	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1	Medical and other services (see instructions)		1
2	Medical and other services reimbursed under OPPS (see instructions).	18,573	2
3	PPS payments	12,550	3
4	Outlier payment (see instructions)		4
5	Enter the hospital specific payment to cost ratio (see instructions)		5
6	Line 2 times line 5		6
7	Sum of lines line 3 plus line 4 divided by line 6		7
8	Transitional corridor payment (see instructions)		8
9	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200		9
10	Organ acquisition		10
11	Total cost (sum of lines 1 and 10) (see instructions)		11
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12	Ancillary service charges		12
13	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)		13
14	Total reasonable charges (sum of lines 12 and 13)		14
	Customary charges		
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis		15
16	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)		16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)		17
18	Total customary charges (see instructions)		18
19	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		20
21	Lesser of cost or charges (line 11 minus line 20) (for CAH, see instructions)		21
22	Interns and residents (see instructions)		22
23	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, §2148)		23
24	Total prospective payment (sum of lines 3, 4, 8 and 9)	12,550	24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25	Deductibles and coinsurance (see instructions)		25
26	Deductibles and Coinsurance relating to amount on line 24 (see instructions)	2,427	26
27	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (see instructions)	10,123	27
28	Direct graduate medical education payments (from Worksheet E-4, line 50)		28
29	ESRD direct medical education costs (from Worksheet E-4, line 36)		29
30	Subtotal (sum of lines 27 through 29)	10,123	30
31	Primary payer payments		31
32	Subtotal (line 30 minus line 31)	10,123	32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33	Composite rate ESRD (from Worksheet I-5, line 11)		33
34	Allowable bad debts (see instructions)		34
35	Adjusted reimbursable bad debts (see instructions)		35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)		36
37	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)	10,123	37
38	MSP-LCC reconciliation amount from PS&R		38
39	Other adjustments (specify) (see instructions)		39
40	Subtotal (line 37 plus or minus lines 39 minus 38)	10,123	40
41	Interim payments	10,123	41
42	Tentative settlement (for contractors use only)		42
43	Balance due provider/program (line 40 minus the sum of lines 41, and 42)		43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		44
	PART B - MEDICAL AND OTHER HEALTH SERVICES TO BE COMPLETED BY CONTRACTOR		
90	Original outlier amount (see instructions)		90
91	Outlier reconciliation adjustment amount (see instructions)		91
92	The rate used to calculate the Time Value of Money		92
93	Time Value of Money (see instructions)		93
94	Total (sum of lines 91 and 93)		94

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CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 420087	PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET E, PART B
Medicare - Title XVIII - SNF			
Rev. 2 - 08-11			40-587

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ROPER HOSPITAL - CHARLESTON, SC
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CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 420087	PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET E-1, PART II

Medicare -Title XVIII - Hospital

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I, line 14, column 15	14,255	1
2	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12	37,537	2
3	Medicare HMO days from Wkst S-3, Part I, column 6. line 2		3
4	Total inpatient bed days from S-3, Part I column 8 sum of lines 1, 8-12	68,120	4
5	Total hospital charges from Wkst C, Part I, column 8 line 200	1,199,988,864	5
6	Total hospital charity care charges from Wkst S-10, column 3 line 20	52,557,736	6
7	CAH only - The reasonable cost incurred for the purchase of certified HIT technology from Worksheet S-2, Part I line 168		7
8	Calcualtion of the HIT incentive payment (see instructions)		8

INPATIENT HOSPITAL SERVICES UNDER PPS & CAH

30	Initial/interim HIT payment(s).		30
31	Other Adjustments (specify)		31
32	Balance due provider (line 8 minus line 30 ± line 31)		32

FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4031.1)

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CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 420087	PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET E-3, PART III

Medicare -Title XVIII - SNF

PART III - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IRF PPS

1	Net Federal PPS payment (see instructions)	10,139,729	1
2	Medicare SSI ratio (IRF PPS only) (see instructions)	0.021300	2
3	Inpatient Rehabilitation LIP payments (see instructions)	350,966	3
4	Outlier payments	1,063,693	4
5	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)		5
6	New teaching program adjustment (see instructions)		6
7	Current year unweighted FTE count of I&R other than FTEs in the first 3 years of a "new teaching program" (see instructions)		7
8	Current year unweighted I&R FTE count for residents within the first 3 years of a "new teaching program" (see instructions)		8
9	Intern and resident count for IRF PPS medical education adjustment (see instructions)		9
10	Average daily census (see instructions)	41.70	10
11	Medical Education Adjustment Factor {((1 + (line 9/line 10)) raised to the power of .6876 -1}.		11
12	Medical Education Adjustment (line 1 multiplied by line 11).		12
13	Total PPS Payment (sum of lines 1, 3, 4 and 12)	11,554,388	13
14	Nursing and Allied Health Managed Care payment (see instructions)		14
15	Organ acquisition		15
16	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)		16
17	Subtotal (see instructions)	11,554,388	17
18	Primary payer payments		18
19	Subtotal (line 17 less line 18).	11,554,388	19
20	Deductibles	75,844	20
21	Subtotal (line 19 minus line 20)	11,478,544	21
22	Coinsurance	160,531	22
23	Subtotal (line 21 minus line 22)	11,318,013	23
24	Allowable bad debts (exclude bad debts for professional services) (see instructions)		24
25	Adjusted reimbursable bad debts (see instructions)		25
26	Allowable bad debts for dual eligible beneficiaries (see instructions)		26
27	Subtotal (sum of lines 23 and 25)	11,318,013	27
28	Direct graduate medical education payments (from Worksheet E-4, line 49)		28
29	Other pass through costs (see instructions)	12,580	29
30	Outlier payments reconciliation		30
31	\Other adjustments (specify) (see instructions)		31
32	Total amount payable to the provider (see instructions)	11,330,593	32
33	Interim payments	11,233,722	33
34	Tentative settlement (for contractor use only)		34
35	Balance due provider/program (line 32 minus the sum lines 33 and 34)	96,871	35
36	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		36

TO BE COMPLETED BY CONTRACTOR

50	Original outlier amount from Worksheet E-3, Part III, line 4 (see instructions)	1,063,693	50
51	Outlier reconciliation adjustment amount (see instructions)		51
52	The rate used to calculate the Time Value of Money (see instructions)		52
53	Time Value of Money (see instructions)		53

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BALANCE SHEET	Provider CCN: 420087	PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET G

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

	Assets (Omit cents)	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1	2	3	4	
	CURRENT ASSETS					
1	Cash on hand and in banks	61,707				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	60,678,992				4
5	Other receivables	3,717,553				5
6	Allowances for uncollectible notes and accounts receivable					6
7	Inventory	6,178,876				7
8	Prepaid expenses	1,025,858				8
9	Other current assets					9
10	Due from other funds	96,492,072				10
11	Total current assets (sum of lines 1-10)	168,155,056				11
	FIXED ASSETS					
12	Land	3,872,178				12
13	Land improvements	2,649,676				13
14	Accumulated depreciation	-1,726,853				14
15	Buildings	231,664,160				15
16	Accumulated depreciation	-117,412,584				16
17	Leasehold improvements	5,761,072				17
18	Accumulated depreciation	-2,767,167				18
19	Fixed equipment	1,962,426				19
20	Accumulated depreciation	-1,155,007				20
21	Automobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	99,080,920				23
24	Accumulated depreciation	-56,738,972				24
25	Minor equipment depreciable					25
26	Accumulated depreciation					26
27	HIT designated Assets					27
28	Accumulated depreciation					28
29	Minor equipment-nondepreciable					29
30	Total fixed assets (sum of lines 12-29)	165,189,856				30
	OTHER ASSETS					
31	Investments	252,515				31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	13,122,305				34
35	Total other assets (sum of lines 31-34)	13,374,820				35
36	Total assets (sum of lines 11, 30, and 35)	346,719,744				36
	Liabilities and Fund Balances (Omit cents)					
	CURRENT LIABILITIES					
37	Accounts payable	1,868,197				37
38	Salaries, wages, and fees payable					38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)	491,441				40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds	-189,055,056				43
44	Other current liabilities	6,473,837				44
45	Total current liabilities (sum of lines 37 thru 44)	-180,221,584				45
	LONG TERM LIABILITIES					
46	Mortgage payable					46
47	Notes payable	1,494,426				47
48	Unsecured loans					48
49	Other long term liabilities	992,333				49

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BALANCE SHEET		Provider CCN: 420087	PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET G	
(If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)					
	Assets (Omit cents)	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1	2	3	4	
50	Total long term liabilities (sum of lines 46 thru 49)	2,486,759				50
51	Total liabilities (sum of lines 45 and 50)	-177,734,832				51
CAPITAL ACCOUNTS						
52	General fund balance	524,454,560				52
53	Specific purpose fund					53
54	Donor created - endowment fund balance - restricted					54
55	Donor created - endowment fund balance - unrestricted					55
56	Governing body created - endowment fund balance					56
57	Plant fund balance - invested in plant					57
58	Plant fund balance - reserve for plant improvement, replacement, and expansion					58
59	Total fund balances (sum of lines 52 thru 58)	524,454,560				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	346,719,744				60
FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4040)						
Rev. 2					40-601 - 08-11	

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ROPER HOSPITAL - CHARLESTON, SC
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STATEMENT OF CHANGES IN FUND BALANCES		Provider CCN: 420087	PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET G-1

		GENERAL FUND		SPECIFIC PURPOSE FUND		ENDOWMENT FUND		PLANT FUND		
		1	2	3	4	5	6	7	8	
1	Fund balances at beginning of period		468,354,848							1
2	Net income (loss) (from Worksheet G-3, line 29)		56,176,892							2
3	Total (sum of line 1 and line 2)		524,531,744							3
4										4
5	FOUNDATION MINOR MEDICAL EQUIP	15,920								5
6	FOUNDATION ABI MACHINE	36,493								6
7	CLOSE OUT CORP 32 INTERCOMPANY	10,034								7
8	FUNDS FOR 7TH FLOOR RENOVATIONS	3,073								8
9	CLEAR INVESTMENT IN WASC	474,156								9
10	Total additions (sum of lines 4-9)		539,676							10
11	Subtotal (line 3 plus line 10)		525,071,424							11
12										12
13	CLOSE OUT CORP 01 DUE TO/FROM CORP	76,851								13
14	CLOSE OUT CORP 36 INTERCOMPANY	174								14
15	CLOSE OUT CORP 31 INTERCOMPANY	539,837								15
16										16
17										17
18	Total deductions (sum of lines 12-17)		616,862							18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		524,454,560							19

FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4040)

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STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider CCN: 420087	PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET G-2, PARTS I & II

PART I - PATIENT REVENUES

	REVENUE CENTER	INPATIENT	OUTPATIENT	TOTAL	
		1	2	3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	Hospital	108,515,144		108,515,144	1
2	Subprovider IPF				2
3	Subprovider IRF	22,645,702		22,645,702	3
4	Subprovider (Other)				4
5	Swing bed - SNF				5
6	Swing bed - NF				6
7	Skilled nursing facility				7
8	Nursing facility				8
9	Other long term care				9
10	Total general inpatient care services (sum of lines 1-9)	131,160,848		131,160,848	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	Intensive care unit	30,389,596		30,389,596	11
12	Coronary care unit				12
13	Burn intensive care unit				13
14	Surgical intensive care unit				14
15	Other special care (specify)				15
16	Total intensive care type inpatient hospital services (sum of of lines 11-15)	30,389,596		30,389,596	16
17	Total inpatient routine care services (sum of lines 10 and 16)	161,550,432		161,550,432	17
18	Ancillary services	451,034,944		451,034,944	18
19	Outpatient services		597,734,976	597,734,976	19
20	Rural Health Clinic (RHC)				20
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency		8,155,632	8,155,632	22
23	Ambulance	1,913,305	3,345,017	5,258,322	23
24	Outpatient rehabilitation providers				24
25	ASC				25
26	Hospice				26
27	Other (specify)	2,660,082	2,737,132	5,397,214	27
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	617,158,784	611,972,736	1,229,131,520	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Wkst. A, column 3, line 200)		341,463,040	29
30	Add (specify)			30
31				31
32				32
33				33
34				34
35		2		35
36	Total additions (sum of lines 30-35)		2	36
37	Deduct (specify)			37
38				38
39				39
40				40
41				41
42	Total deductions (sum of lines 37-41)			42
43	Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)		341,463,040	43

FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4040)

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STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 420087	PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET G-3

	Description		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	1,229,131,520	1
2	Less contractual allowances and discounts on patients' accounts	836,544,896	2
3	Net patient revenues (line 1 minus line 2)	392,586,656	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	341,463,040	4
5	Net income from service to patients (line 3 minus line 4)	51,123,632	5
	OTHER INCOME		
6	Contributions, donations, bequests, etc		6
7	Income from investments		7
8	Revenues from telephone and telegraph service		8
9	Revenue from television and radio service		9
10	Purchase discounts		10
11	Rebates and refunds of expenses		11
12	Parking lot receipts		12
13	Revenue from laundry and linen service		13
14	Revenue from meals sold to employees and guests	1,803,981	14
15	Revenue from rental of living quarters		15
16	Revenue from sale of medical and surgical supplies to other than patients		16
17	Revenue from sale of drugs to other than patients		17
18	Revenue from sale of medical records and abstracts	1,078	18
19	Tuition (fees, sale of textbooks, uniforms, etc.)		19
20	Revenue from gifts, flowers, coffee shops, and canteen		20
21	Rental of vending machines		21
22	Rental of hospital space		22
23	Governmental appropriations		23
24	Other (specify)		24
24.00	OTHER INCOME	864,836	24.00
24.02	OTHER LAB INCOME	218,771	24.02
24.03	CPE INCOME	1,400	24.03
24.04	OTHER RADIOLOGY INCOME	40,439	24.04
24.05	HEART & VASCULAR CENTER INCOME	35,028	24.05
24.06	OTHER PHARMACY INCOME	2,000	24.06
24.07	OTHER CARDIAC REHAB INCOME	80,261	24.07
24.08	OTHER THERAPY INCOME	23,775	24.08
24.09	OTHER COMMUNITY PROGRAMS INCOME	1,702,294	24.09
24.11	OTHER ONCOLOGY INCOME	54,664	24.11
24.12	GARAGE REVENUE	93,038	24.12
24.14	OTHER NON-OPERATING LOSS(GAIN)	5,458	24.14
24.15	NON-OPERATING INCOME	126,235	24.15
24.16	ROUNDING	2	24.16
25	Total other income (sum of lines 6-24)	5,053,260	25
26	Total (line 5 plus line 25)	56,176,892	26
27	Other expenses (specify)		27
28	Total other expenses (sum of line 27 and subscripts)		28
29	Net income (or loss) for the period (line 26 minus line 28)	56,176,892	29

FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4040)

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ROPER HOSPITAL - CHARLESTON, SC
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ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS						Provider CCN: 420087		PERIOD: FROM 01/01/2011 TO 12/31/2011		WORKSHEET H	
COST CENTER DESCRIPTIONS (omit cents)	SALARIES	EMPLOYEE BENEFITS	TRANSPORTATION (see instructions)	CONTRACTED/ PURCHASED SERVICES	OTHER COSTS	TOTAL (sum of cols. 1 thru 5)	RECLASSIFICATIONS	RECLASSIFIED TRIAL BALANCE (col. 6 + col. 7)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 8 + col. 9)	
	1	2	3	4	5	6	7	8	9	10	
GENERAL SERVICE COST CENTERS											
1 Capital Related-Bldgs. and Fixtures											1
2 Capital Related-Movable Equipment											2
3 Plant Operation & Maintenance											3
4 Transportation (see instructions)											4
5 Administrative and General	1,917,401		12,547	31,039	350,619	2,311,606	-206,549	2,105,057	-304,378	1,800,679	5
HHA REIMBURSABLE SERVICES											
6 Skilled Nursing Care	1,386,797		124,504		15	1,511,316	206,549	1,717,865		1,717,865	6
7 Physical Therapy	1,786,163		156,428		25	1,942,616		1,942,616		1,942,616	7
8 Occupational Therapy	374,549		39,711		12	414,272		414,272		414,272	8
9 Speech Pathology	128,030		13,687		10	141,727		141,727		141,727	9
10 Medical Social Services	117,429		4,425		7	121,861		121,861		121,861	10
11 Home Health Aide	88,731		32,151			120,882		120,882		120,882	11
12 Supplies (see instructions)					170,103	170,103		170,103		170,103	12
13 Drugs											13
14 DME											14
HHA NONREIMBURSABLE SERVICES											
15 Home Dialysis Aide Services											15
16 Respiratory Therapy											16
17 Private Duty Nursing											17
18 Clinic											18
19 Health Promotion Activities											19
20 Day Care Program											20
21 Home Delivered Meals Program											21
22 Homemaker Service											22
23 All Others											23
24 Total (sum of lines 1-23)	5,799,100		383,453	31,039	520,791	6,734,383		6,734,383	-304,378	6,430,005	24
Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.											
FORM CMS 2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN HCFA PUB. 15-II, SECTION 4041)											
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CALCULATION OF CAPITAL PAYMENT	Provider CCN: 420087	PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET L

Medicare -Title XVIII - Hospital

PART I - FULLY PROSPECTIVE METHOD

CAPITAL FEDERAL AMOUNT

1	Capital DRG other than outlier	5,087,362	1
2	Capital DRG outlier payments	361,182	2
3	Total inpatient days divided by number of days in the cost reporting period (see instructions)	186.63	3
4	Number of interns & residents (see instructions)		4
5	Indirect medical education percentage (see instructions)		5
6	Indirect medical education adjustment (line 1 times line 5)		6
7	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, Part A line 30) (see instructions)	0.071800	7
8	Percentage of Medicaid patient days to total days reported on Worksheet S-2, Part I, line 24. (see instructions)	0.097700	8
9	Sum of lines 7 and 8	0.169500	9
10	Allowable disproportionate share percentage (see instructions)	0.034900	10
11	Disproportionate share adjustment (line 10 times lines 1)	177,549	11
12	Total prospective capital payments (sum of lines 1-2, 6 and 11)	5,626,093	12

PART II - PAYMENT UNDER REASONABLE COST

1	Program inpatient routine capital cost (see instructions)		1
2	Program inpatient ancillary capital cost (see instructions)		2
3	Total inpatient program capital cost (line 1 plus line 2)		3
4	Capital cost payment factor (see instructions)		4
5	Total inpatient program capital cost (line 3 x line 4)		5

PART III - COMPUTATION OF EXCEPTION PAYMENTS

1	Program inpatient capital costs (see instructions)		1
2	Program inpatient capital costs for extraordinary circumstances (see instructions)		2
3	Net program inpatient capital costs (line 1 minus line 2)		3
4	Applicable exception percentage (see instructions)		4
5	Capital cost for comparison to payments (line 3 x line 4)		5
6	Percentage adjustment for extraordinary circumstances (see instructions)		6
7	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		7
8	Capital minimum payment level (line 5 plus line 7)		8
9	Current year capital payments (from Part I, line 12 as applicable)		9
10	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		10
11	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		11
12	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		12
13	Current year exception payment (if line 12 is positive, enter the amount on this line)		13
14	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		14
15	Current year allowable operating and capital payment (see instructions)		15
16	Current year operating and capital costs (see instructions)		16
17	Current year exception offset amount (see instructions)		17

FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTIONS 4064.1 - 4064.3)

40-646 - 08-11 Rev. 2

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Cost Report data

420065
ST. FRANCIS XAVIER BON SECOURS
2095 HENRY TECKLENBURG DRIVE
CHARLESTON, SC 29414

[Electronic Record Code: 267623 - 1996]
Type of Facility: Short Term Acute Care
Type of Control: Voluntary Nonprofit, Other
Classification: Urban

Bed Size:	204
Total Annual Discharges:	8,307
Total Patient Revenue:	$496,470,496

Period: 01/01/2010 - 12/31/2010
Status: As Submitted

Fiscal Intermediary: Palmetto Government Benefits Administrators

Medicare Inpatient Characteristics

DSH Ratio:	0.133300
DSH Amount:	$2,640,363
Outlier Amount:	$393,179
IME Amount:	$0
GME Amount:	$0
Total IP Reimbursement:	$24,658,504
Total IP Costs:	$28,891,315
NPR Date:	00/00/0000
NPR Settlement Amount:	$-255,773
NPR Settlement Percent:	1.04 %

[Date Generated: 03/20/2013]

Source
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Legend:

Identification
A hospital's Medicare provider number, name, and address are taken from Worksheet S-2. The Electronic Code is a code assigned by CostReportData.com to assist in resolving questions.

Type of Facility
The type of facility is determined from the last four digits of its Medicare provider number.

Type of Control
A hospital's type of control is taken from the HCRIS file.

Bed Size
The number of staffed beds is taken from Worksheet S-3, Part I, line 12, col.1. Cost report instructions define staffed beds as, "the number of beds available for use by patients at the end of the cost reporting period. A bed means an adult bed, pediatric bed, birthing room, or newborn bed maintained in a patient care area for lodging patients in acute, long term, or domiciliary areas of the hospital. Beds in labor room, birthing room, postanesthesia, postoperative recovery rooms, outpatient areas, emergency rooms, ancillary departments, nurses' and other staff residences, and other such areas which are regularly maintained and utilized for only a portion of the stay of patients (primarily for special procedures or not for inpatient lodging) are not termed a bed for these purposes.

Total Annual Discharges
The total number of inpatient discharges (all payors) is taken from Worksheet S-3, part I, line 12, column 15.

Total Patient Revenue
The total patient revenue (inpatient and outpatient) is taken from Worksheet G-2, part I, line 25, column 3.

Period
The beginning and ending dates for a cost report are taken from Worksheet S-2, line 17.

Status
The status of a cost report is taken from the HCRIS file.

Fiscal Intermediary
Medicare Fiscal Intermediaries (FIs) are private insurance companies that serve as the federal government's agents in the administration of the Medicare program, including the payment of claims. The name of the FI is obtained from a hospital's most recent Medicare cost report.

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Disproportionate Share (DSH Amount and DSH Ratio)
Medicare provides additional payment to hospitals that treat a disproportionate share of low-income patients. Qualifying hospitals receive a percentage increase in Medicare payments. This percentage increase varies depending on the ratio of low income patients and on certain statutory calculations. The Disproportionate SHare (DSH) ratio is taken from Worksheet E, Part A, line 4.03. The amount of DSH payments is from Worksheet E, Part A, line 4.04.

Outlier Amount
Medicare makes additional payments to hospitals for patients with costs that are extraordinarily high due to severity of illness and/or complicating conditions. The amount of outlier payments is from Worksheet E, Part A, line 2.01 (or line 2 for discharges occurring prior to October 1, 1997).

IME Amount
Teaching hospitals receive additional Medicare payment due to the indirect costs associated with medical education programs. These payments are intended to cover the costs of additional tests and procedures ordered by interns and residents over and above what would have been ordered by more experienced physicians. The amount of the Indirect Medical Education (IME) adjustment is from Worksheet E, Part A, line 3.24 (or line 3.03 for cost reporting periods ending on or before September 30, 1997).

GME Amount
Medicare pays a hospital for the costs of an approved direct Graduate Medical Education (GME) program. These costs include the direct cost of salaries and benefits for interns, residents, and teachers. The amount of GME payment is from Worksheet E, Part A, line 11.

Total IP Reimbursement
The total amount of Medicare inpatient reimbursement for the cost reporting period is from Worksheet E, Part A, line 16 for PPS hospitals or from Worksheet E-3, Part I, line 17 or Worksheet E-3, Part II, Line 30 for non-PPS hospitals.

Total IP Costs
Total IP Costs corresponding to Total IP Reimbursement are calculated in the cost report and summarized on Worksheet D-1, Part II, line 49.

NPR Date
At the close of its fiscal year, a provider must submit a cost report to the FI showing the costs it incurred during the fiscal year and the proportion of those costs to be allocated to Medicare. The FI reviews the cost report, determines the total amount of Medicare reimbursement due the provider and issues the provider a Notice of Program Reimbursement (NPR). The NPR date is obtained from the most recent cost report data (HCRIS). There is no NPR date for cost reports as submitted or as amended by the provider (see Status above).

NPR Settlement Amount
The NPR Settlement Amount is the Balance due provider/(Program). It is the difference between the Total IP Reimbursement (above) and the total interim payments for the cost reporting period less any tentative settlements previously made by the FI. The Balance due provider/(Program) is from Worksheet E, Part A, line 29 for PPS hospitals or from Worksheet E-3, Part I, line 20 or Worksheet E-3, Part II, Line 33 for non-PPS hospitals.

NPR Settlement Percentage
This NPR settlement percentage is the NPR settlement amount as a percentage of total inpatient reimbursement. (It is calculated from the data elements previously defined.)

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ST. FRANCIS XAVIER BON SECOURS - CHARLESTON, SC
Cost report status - As Submitted
[Record code 267623 - 1996]

HOSPITAL AND HOSPITAL HEALTHCARE COMPLEX IDENTIFICATION DATA	PROVIDER NO 420065	PERIOD FROM 01/01/2010 TO 12/31/2010	WORKSHEET S-2 PART I

Hospital and Hospital Health Care Complex Address:

1	Street: 2095 HENRY TECKLENBURG DRIVE		P.O.Box:	1
1.01	City: CHARLESTON	State: SC ZIP: 29414	County: CHARLESTON	1.01

Hospital and Hospital-Based Component Identification:

	Component	Component Name	Provider Number	NPI Number	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
	0	1	2	2.01	3	4	5	6	
2	Hospital	ST. FRANCIS XAVIER BON SECOURS	420065		10/01/96		P	O	2
3.00	Subprovider								3.00
4	Swing Beds-SNF								4
5	Swing Beds-NF								5
6	Hospital-Based SNF								6
7.00	Hospital-Based NF								7.00
8	Hospital-Based OLTC								8
9.00	Hospital-Based HHA								9.00
11.00	Separately Certified ASC								11.00
12.00	Hospital-Based Hospice								12.00
14.00	Hospital-Based Health Clinic								14.00
15.00	Outpatient Rehab. Clinic								15.00
16.00	Renal Dialysis								16.00

17	Cost Reporting Period	From: 01/01/2010	To: 12/31/2010		17
			1	2	
18	Type of Control (see instructions)		2		18

Type of Hospital/subprovider (see instructions)

19	Hospital	1		19
20.00	Subprovider			20.00

Other Information

21	Indicate if your hospital is either (1) urban or (2) rural at the end of the cost reporting period in column 1. If your hospital is geographically classified or located in a rural area, is your bed size in accordance with CFR 42 412.105 less than or equal to 100 beds, enter in column 2 "Y" for yes or "N" for no.					21
21.01	Does your facility qualify and is currently receiving payment for disproportionate share hospital adjustment in accordance with 42 CFR 412.106?Enter in column 1 "Y" for yes or "N" for no. Is this facility subject to the provisions of 42 CFR 412.106(c)(2) (Pickle amendment hospitals)? Enter in column 2 "Y" for yes or "N" for no.			Y	N	21.01
21.02	Has your facility received a new geographic reclassification status changes after the first day of the cost reporting period from rural to urban and vice versa? Enter "Y" for yes and "N" for no. If yes, enter in column 2 the effective date (mm/dd/yyyy) (See instructions)					21.02
21.03	Enter in column 1 your geographic location either (1) urban (2) rural If you answered urban in column 1 indicate if you received either a wage or standard geographic reclassification to a rural location, enter in column 2 "Y" for yes and "N" for no. If column 2 is yes enter in column 3 the effective date (mm/dd/yyyy) (see instruction). Does your facility contain 100 or fewer beds in accordance with 42 CFR 412.105? Enter in column 4 "Y" for yes and "N" for no. Enter in column 5 the providers actual MSA or CBSA	1	N		N 16700	21.03
21.04	For standard Geographic classification (not wage), what is your status at the beginning of the cost reporting period. Enter (1) urban and (2) rural.			1		21.04
21.05	For standard Geographic classification (not wage), what is your status at the end of the cost reporting period. Enter (1) urban and (2) rural.			1		21.05
21.06	Does this hospital qualifies for the three year transition (or applicable extension) of hold harmless payments for small rural hospital under the prospective payment system for hospital outpatient services under DRA §5105 or MIPPA §147, ACA §3121, or MMEA §108? (See instructions). Enter "Y" for yes, and "N" for no.			N		21.06
21.07	Does this hospital qualify as an SCH with 100 or fewer beds under MIPPA§147? Enter "Y" for yes and "N" for no.(See instructions) Is this an SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 or MMEA §108? Enter in colun 2 "Y" for yes or "N" for no.(See instructions)				N	21.07
21.08	Which method is used to determine Medicaid days on S-3, Part I, col. 5 Enter in column 1, "1" if it is based on date of admission, "2" if it based on census days, or "3" if it is based on date of discharge. Is this method different than the method used in the preceeding cost reporting period? Enter in column 2,"Y" for yes or "N" for no.				N	21.08
22	Are you classified as a referral center?			N		22
23	Does this facility operate a transplant center? If yes, enter certification date(s) in column 2 and termination date(s) in column 3 (mm/dd/yyyy) below:			N		23
23.01	If this is a Medicare certified kidney transplant center, enter the certification date in col. 2 and termination in col. 3.					23.01
23.02	If this is a Medicare certified heart transplant center, enter the certification date in col. 2 and termination in col. 3.					23.02
23.03	If this is a Medicare certified liver transplant center, enter the certification date in col. 2 and termination in col. 3.					23.03
23.04	If this is a Medicare certified lung transplant center, enter the certification date in col. 2 and termination in col. 3.					23.04
23.05	If Medicare pancreas transplant are performed see instructions for entering certification and termination date.					23.05

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HOSPITAL AND HOSPITAL HEALTHCARE COMPLEX IDENTIFICATION DATA	PROVIDER NO 420065	PERIOD FROM 01/01/2010 TO 12/31/2010	WORKSHEET S-2 PART I

23.06	If this is a Medicare certified intestinal transplant center, enter the certification date in col. 2 and termination in col. 3.					23.06
23.07	If this is a Medicare certified islet transplant center, enter the certification date in col. 2 and termination in col. 3.					23.07
24	If this is an organ procurement organization (OPO), enter the OPO number in column 2 termination date in col 3.					24
24.01	If this is a Medicare Transplant Center, enter CCN in col. 2, the certification or recertification date after (12/26/2007) in column 3 (mm/dd/yyyy).					24.01
25	Is this a teaching hospital or affiliated with a teaching hospital and you are receiving payments for I & R?	N				25
25.01	Is this teaching program approved in accordance with CMS Pub. 15-I, chapter 4?					25.01
25.02	If line 25.01 is yes, was Medicare participation and approved teaching program status in effect during the first month of the cost reporting period? If yes, complete Worksheet E-3, Part IV. If no, complete Worksheet D-2, Part II.					25.02
25.03	As a teaching hospital, did you elect cost reimbursement for physicians as defined in CMS Pub. 15-I, section 2148? If yes, complete Worksheet D-9.	N				25.03
25.04	Are you claiming costs on line 70 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N				25.04
25.05	Has your facility direct GME FTE cap (column 1) or IME FTE cap (column 2) been reduced under 42 CFR §413.79(c)(3) or 42 CFR §412.105(f)(1)(iv)(B)? Enter "Y" for yes and "N" for no in the applicable columns. (see instructions)	N	N			25.05
25.06	Has your facility received additional direct GME FTE resident cap slots or IME FTE residents cap slots under 42 CFR 413.79(c)(4)or 42 CFR 412.105(f)(1)(iv)(C)? Enter "Y" for yes and "N" for no in the applicable columns (see instructions).	N	N			25.06
25.07	Has your facility trained residents in non-provider setting during the cost reporting period? Enter "Y" for yes or "N" for no in column 1.					25.07
25.08	If line 25.07 is yes, enter in column 1 the weighted number of non-primary care FTE residents attributable to rotations occurring in all non-provider settings.					25.08
25.09	If line 25.07 is yes, use lines 25.09 through 25.59 as necessary to identify the program name in column 1, the program code in column 2, and the number unweighted primary care residents FTEs by program in column 3 for each primary care specialty program in which residents are trained.(see instructions)					25.09
26	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the C/R period Enter beginning and ending dates of SCH status on line 26.01. Subscript line 26.01 for number of periods in excess of one and enter subsequent dates					26
26.01	Enter the applicable SCH dates: (see instructions)	Beginning:	Ending:			26.01
27	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? If yes, enter the agreement date (mm/dd/yyyy) in column 2.	N				27
28	If this facility contains a hospital-based SNF, are all patients under managed care or there were no Medicare utilization enter "Y", if "N" complete lines 28.01 and 28.02.					28
28.01	If hospital-based SNF, enter appropriate transition period 1, 2, 3, or 100 in column 1. Enter in columns 2 and 3 the wage index adjustment factor before and on or after the October 1st (see instrctions)					28.01
28.02	Enter in column 1 the hospital based SNF facility specific rate (from your fiscal intermediary) if you have not transitioned to 100% SNP PPS payment. In column 2 enter the facility classification Urban(1) or Rural(2). In column 3, enter the SNF MSA code or two character state code if a Rural based facility. In column 4, enter the SNF CBSA code or two character state code if a Rural based facility					28.02
	A notice published in the "Federal Register" Vol. 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. Enter in column 1 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 6, column 3. Indicate in column 2 "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (See instructions)					
28.03	Staffing					28.03
28.04	Recruitment					28.04
28.05	Retention of employees					28.05
28.06	Training					28.06
28.07	Other (Specify)					28.07
29	Is this a rural hospital with a certified SNF which has fewer than 50 beds in the aggregate for both components, using the swing bed optional method of reimbursement?	N				29
30	Does this hospital qualify as a rural primary care hospital (RPCH)/Critical Access Hospital (CAH)? (see 42 CYR 485.606ff)	N				30
30.01	If so, is this the initial 12 month period for the facility operated as an RPCH/CAH? See 42 CFR 413.70.					30.01
30.02	If this facility qualifies as an RPCH/CAH, has it elected the all-inclusive method of payment for outpatient services? (See instructions)					30.02
30.03	If this facility qualifies as a CAH is it eligible for cost reimbursement for ambulance services? If yes, enter in column 2 the date of eligibility determination (date must be on or after 12/21/2000)					30.03
30.04	If this facility qualifies as a CAH is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes and "N" for no. If yes, the GME elimination would not be on Worksheet B, Part I, column 26 and the program would be cost reimbursed. If yes also complete Worksheet D-2, Part II.					30.04
31	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR 412.113(c).	N				31
31.01		N				31.01
31.02		N				31.02
Miscellaneous Cost Reporting information						
32	Is this an all-inclusive provider? If yes, enter the method used (A, B, or E only) in column 2.	N				32
33	Is this a new hospital under 42 CFR 412.300 PPS capital? Enter "Y for yes and "N" for no in column 1. If yes, for cost reporting periods beginning on or after October 1, 2002, do you elect to be reimbursed at 100% Federal capital payment? Enter "Y for yes and "N" for no in column 2.	N				33

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HOSPITAL AND HOSPITAL HEALTHCARE COMPLEX IDENTIFICATION DATA	PROVIDER NO 420065	PERIOD FROM 01/01/2010 TO 12/31/2010	WORKSHEET S-2 PART I

34	Is this a new hospital under 42 CFR 413.40(f)(1)(i) TEFRA?	N			34
35	Have you established a new subprovider (excluded unit) under 42 CFR 413.40(f)(1)(i)?	N			35
35.01		N			35.01
		V	XVIII	XIX	
	Prospective Payment System (PPS)-Capital	1	2	3	
36	Do you elect fully prospective payment methodology for capital costs? (See instructions)		Y		36
36.01	Does your facility qualify and receive payment for disproportionate share in accordance with 42 CFR 412.320? (See instructions)		Y		36.01
37	Do you elect hold harmless payment methodology for capital costs? (See instructions)		N		37
37.01	If you are a hold harmless provider, are you filing on the basis of 100% of the Federal rate?				37.01
	Title XIX inpatient services				
38	Do you have title XIX inpatient hospital services?	Y			38
38.01	Is this hospital reimbursed for title XIX through the cost report either in full or in part?				38.01
38.02	Does the title XIX program reduce capital following the Medicare methodology?				38.02
38.03	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (See instructions)	N			38.03
38.04	Do you operate an ICF/MF facility for purposes of title XIX?	N			38.04
40	Are there any related organization or home office costs as defined in CMS Pub. 15-1, Chapter 10? If yes, and this facility is part of a chain organization, enter in col. 2 the chain home office chain number. (See inst.) If this facility is part of a chain organization enter the name and address of the home office on lines 40.01-40.03.	Y	42H055		40
40.01	Name: CAREALLIANCE HEALTH SERVICES	FI/Contractor's Name: PALMETTO GBA	FI/Contractor's Number:		40.01
40.02	Street: 315 CALHOUN ST STE 107	PO Box:			40.02
40.03	City:	State: SC	Zip Code: 29401		40.03
41	Are provider based physicians' costs included in Worksheet A?				41
42	Are physical therapy services provided by outside suppliers?	N			42
42.01	Are occupational therapy services provided by outside suppliers?	N			42.01
42.02	Are speech pathology services provided by outside suppliers?	N			42.02
43	Are respiratory therapy services provided by outside suppliers?	N			43
44	If you are claiming cost for renal services on Worksheet A, are they inpatient services only?	Y			44
45	Have you changed your cost allocation methodology from the previously filed cost report? See CMS Pub. 15-II, section 3617. If yes, enter the approval date (mm/dd/yyyy) in column 2.	N			45
45.01	Was there a change in the statistical basis?				45.01
45.02	Was there a change in the order of allocation?				45.02
45.03	Was there a change to the simplified cost finding method?				45.03
46	If you are participating in the NHCMQ demonstration project (must have a hospital-based SNF) during this cost reporting period, enter the phase (see instructions).				46

If this facility contains a provider that qualifies for an exemption from the application of the lower of costs or charges, enter "Y" for each component and type of service that qualifies for the exemption. Enter "N" if not exempt. (See 42 CFR 413.13.)		Part A 1	Part B 2	Outpatient ASC 3	Outpatient Radiology 4	Outpatient Diagnostic 5	
47	Hospital	N	N	N	N	N	47
48	Subprovider						48
49	SNF						49
50	HHA						50
51	Outpatient Rehab. Providers (specify)						51

52	Does this hospital claim expenditures for extraordinary circumstances in accordance with 42 CFR 412.348(e)? (See instructions)			N		52
52.01	If you are a fully prospective or hold harmless provider are you eligible for the special exceptions payment pursuant to 42 CFR 412.348(g)? If yes, complete Worksheet L, Part IV.			N		52.01
53	If you are a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in this C/R period. Enter beginning and ending dates of MDH status on line 53.01. Subscript line 53.01 for number of periods in excess of one and enter subsequent dates.					53
53.01	MDH Period	Beginning:	Ending:			53.01
54	List amounts of malpractice premiums and paid losses:	Premiums:	Paid losses:	and/or Self Insurance:		54
54.01	Are malpractice premiums and paid losses reported in other than the Administrative and General cost center? If yes, submit supporting schedule listing cost centers and amounts contained therein.			N		54.01
55	Does your facility qualify for additional prospective payment in accordance with 42 CFR 412.107. Enter "Y" for yes and "N" for no.			N		55

56	Are you claiming ambulance costs? If yes, enter in column 2 the payment limit provided from your fiscal intermediary and the applicable dates for those limits in column 0. If this is the first year of operation no entry is required in column 2. If column 1 is Y, enter Y or N in column 3 whether this is your first year of operations for rendering ambulance services. Enter in column 4, if applicable, the fee schedules amounts for the period beginning on or after 4/1/2002.	Date 0	Y or N 1	Limit 2	Y or N 3	Fees 4	56
			N				
56.01	Enter subsequent ambulance payment limit as required. Subscript if more than 2 limits apply. Enter in column 4 the fee schedules amounts for initial or subsequent periods as applicable.						56.01
57	Are you claiming nursing and allied health costs? (See instructions)					Y	57

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HOSPITAL AND HOSPITAL HEALTHCARE COMPLEX IDENTIFICATION DATA	PROVIDER NO 420065	PERIOD FROM 01/01/2010 TO 12/31/2010	WORKSHEET S-2 PART I

58	Are you an Inpatient Rehabilitation Facility (IRF), or do you contain an IRF subprovider? Enter in column 1 "Y" for yes and "N" for no. If yes have you made the election for 100% Federal PPS reimbursement? Enter in column 2 "Y for yes and "N" for no. This option is only available for cost reporting periods beginning on or after 1/1/2002 and before 10/1/2002.					N		58
58.01	If line 58 column 1 is Y, does the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter in column 1 "Y" for yes or "N" for no. Is the facility training residents in a new teaching programs in accordance with FR Vol. 70, No. 156 dated August 15, 2005 page 47929? Enter in column 2 "Y" for yes or "N" for no. If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions). If the current cost reporting period covers the beginning of the fourth enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5 . (see instructions)							58.01
59	Are you a Long Term Care Hospital (LTCH), or do you contain a LTCH subprovider? Enter in column 1 "Y" for yes and "N" for no. If yes, have you made the election for 100% Federal PPS reimbursement? Enter in column 2 "Y" for yes and "N" for no. (See instructions)					N		59
60	Are you an Inpatient Psychiatric Facility (IPF), or do you contain an IPF subprovider? Enter in column 1 "Y" for yes and "N" for no. If yes, is the IPF or IPF subprovider a new facility? Enter in column 2 "Y for yes and "N" for no. (see instructions)					N		60
60.01	If line 60 column 1 is Y, does 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. Is the facility training residents in a new teaching programs in accordance with 42 CFR Sec. 412.424 (d)(1)(iii)(2)? Enter in column 2 "Y" for yes or "N" for no. If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions). If the current cost reporting period covers the beginning of the fourth enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5 . (see instructions)							60.01
Multicampus								
61	Is this facility part of a Multicampus hospital that has one or more campuses in different CBSA? Enter "Y" for yes and "N" for no.						N	61
	If line 61 is yes, enter the name in col. 0, County in col. 1, state in col. 2, Zip in col 3, CBSA in col. 4 and FTE/Campus in col. 5.	County	State	ZIP Code	CBSA	FTE/ Campus		
		1	2	3	4	5		
62	Name:							62
Settlement data								
63	Was there a change to the simplified cost finding method?					Y	05/04/11	63
Miscellaneous data								
64	Did this facility incur and report costs for implantable devices charged to patient? Enter in column 1 "Y" for yes or "N" for no.						Y	64

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA	PROVIDER NO 420065	PERIOD FROM 01/01/2010 TO 12/31/2010	WORKSHEET S-3 PART I

Component	No. of Beds	Bed Days Available	I/P Days / O/P Visits / Trips						Total All Patients	OBS Beds		Interns & Residents FTEs			Full Time Equivalent		Discharges				
			Title V	Title XVIII	Not Covered (LTAC only)	Title XIX				Admitted	Not Admitted	Total	Less I&R Replacing Non-Phys. Anest.	Net	Employees on Payroll	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
						Total	OBS Admitted	OBS Not Admitted													
	1	2	3	4	4.01	5	5.01	5.02	6	6.01	6.02	7	8	9	10	11	12	13	14	15	
1 Hospital Adults &Peds. (col 3,4,&5), exclude Swing Beds, OBS Bed, and Hospice Days	193	70,445		12,118		2,104			29,873									2,557	648	8,307	1
2 HMO						4,583															2
3 Hospital Adults &Peds Swing Bed SNF																					3
4 Hospital Adults & Peds. Swing Bed NF																					4
5 Total Adults & Peds. (exclude OBS beds)	193	70,445		12,118		2,104			29,873												5
6 Intensive Care Unit	11	4,015		1,213		194			2,462												6
7 Coronary Care Unit																					7
8 Burn Intensive Care Unit																					8
9 Surgical Intensive Care Unit																					9
10.00 Other Special Care (specify)																					10.00
11 Nursery						457			4,629												11
12 Total (see instructions)	204	74,460		13,331		2,755			36,964						876.43			2,557	648	8,307	12
13 RPCH\CAH visits																					13
14.00 Subprovider																					14.00
15 Skilled Nursing Facility																					15
16 Nursing Facility																					16
17 Other Long Term Care																					17
18 Home Health Agency																					18
20 ASC (Distinct Part)																					20
21 Hospice (Distinct Part)																					21
23 Outpatient Rehab. Provider (specify)																					23
24 RHC/FQHC (specify)																					24
25 Total (sum of lines 12-24)	204														876.43						25
26 Observation Bed Days									1,242												26
27 Ambulance Trips																					27
28 Employee discount days (see instru.)																					28
29 Labor & delivery days (see instructions)																					29

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HOSPITAL WAGE INDEX INFORMATION		PROVIDER NO.: 420065		PERIOD: FROM 01/01/2010 TO 12/31/2010		WORKSHEET S-3. PART II	
PART II - WAGE DATA	Amount Reported	Reclass. of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 1 ± col. 2)	Paid Hours Related to Salaries in col. 3	Average Hourly Wage (col. 3÷ col. 4)	Data Source	
	1	2	3	4	5	6	
SALARIES							
1 Total Salaries (see instructions)	49,050,569	-863,422	48,187,147	1,841,714	26.16		1
2 Non-physician anesthetist Part A							2
3 Non-physician anesthetist Part B							3
4 Physician-Part A							4
4.01 Teaching physician salaries (see instructions)							4.01
5 Physician-Part B	829,064		829,064	6,776	122.34		5
5.01 Non-physician-Part B							5.01
6 Interns & residents (in an approved program)							6
6.01 Contractd Services I&R (see instructions)							6.01
7 Home office personnel							7
8 SNF							8
8.01 Excluded area salaries (see instructions)	473,766	-71,778	401,988	18,426	21.82		8.01
OTHER WAGES & RELATED COSTS							
9 Contract labor (see instructions)	174,411		174,411	4,498	38.77		9
9.01 Pharmacy services under contract							9.01
9.02 Laboratory services under contract							9.02
9.03 Management and administrative services							9.03
10 Contract labor: physician-Part A	162,243		162,243	1,266	128.16		10
10.01 Teaching physician under contract (see instru.)							10.01
11 Home office salaries & wage-related costs	7,186,279		7,186,279	200,370	35.87		11
12 Home office: physician Part A							12
12.01 Teaching physician salaries (see instructions)							12.01
WAGE-RELATED COSTS							
13 Wage-related costs (core)	9,694,474		9,694,474			CMS 339	13
14 Wage-related costs (other)						CMS 339	14
15 Excluded areas	80,106		80.106			CMS 339	15
16 Non-physician anesthetist Part A						CMS 339	16
17 Non-physician anesthetist Part B						CMS 339	17
18 Physician Part A						CMS 339	18
18.01 Part A teaching physicians (see instructions)						CMS 339	18.01
19 Physician Part B	165,212		165,212			CMS 339	19
19.01 Wage-related costs (RHC/FQHC)						CMS 339	19.01
20 Interns & residents (in an approved program)						CMS 339	20
OVERHEAD COSTS - DIRECT SALARIES							
21 Employee Benefits	563	-563					21
22 Administrative & General	4,965,691	-241,845	4,723,846	173,625	27.21		22
22.01 Administrative & General under contract (see inst.)	13,029		13,029	714	18.25		22.01
23 Maintenance & Repairs							23
24 Operation of Plant	763,883		763,883	30,938	24.69		24
25 Laundry & Linen Service							25
26 Housekeeping	1,235,446		1,235,446	94,938	13.01		26
26.01 Housekeeping under contract (see instructions)	30,018		30,018	2,231	13.45		26.01
27 Dietary	1,161,481		1,161,481	81,250	14.30		27
27.01 Dietary under contract (see inst.)	1,134		1,134	88	12.89		27.01
28 Cafeteria							28
29 Maintenance of Personnel							29
30 Nursing Administration	732,857		732,857	20,114	36.44		30
31 Central Services and Supply							31
32 Pharmacy							32
33 Medical Records & Medical Records Library	167,473		167,473	11,894	14.08		33
34 Social Service							34
35 Other General Service							35

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HOSPITAL WAGE INDEX INFORMATION		PROVIDER NO.: 420065		PERIOD FROM 01/01/2010 TO 12/31/2010		WORKSHEET S-3, PART III	
	Amount Reported	Reclass. of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 1 ± col. 2)	Paid Hours Related to Salaries in col. 3	Average Hourly Wage (col. 3 ÷ col. 4)	Data Source	
	1	2	3	4	5	6	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1 Net Salaries (see instructions)	48,265,686	-863,422	47,402,264	1,837,971	25.79		1
2 Excluded area salaries (see instructions)	473,766	-71,778	401,988	18,426	21.82		2
3 Subtotal salaries (line 1 minus line 2)	47,791,920	-791,644	47,000,276	1,819,545	25.83		3
4 Subtotal other wages & related costs (see inst.)	7,522,933		7,522,933	206,134	36.50		4
5 Subtotal wage-related costs (see inst.)	9,694,474		9,694,474		20.63		5
6 Total (sum of lines 3 thru 5)	65,009,327	-791,644	64,217,683	2,025,678	31.70		6
7 Net salaries (see instructions)							7
8 Excluded area salaries							8
9 Subtotal salaries (line 7 minus line 8)							9
10 Subtotal other wages & related costs (see inst.)							10
11 Subtotal wage-related costs (see inst.)							11
12 Total (sum of lines 9 thru 11)							12
13 Total overhead costs (see inst.)	9,071,575	-242,408	8,829,167	415,792	21.23		13

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HOSPITAL UNCOMPENSATED CARE DATA	PROVIDER NO: 420065	PERIOD: FROM: 01/01/2010 TO: 12/31/2010	WORKSHEET S-10

Uncompensated Care Information			
1	Do you have a written charity policy?		1
2	Are patients write-offs identified as charity? If yes answer lines 2.01 thru 2.04		2
2.01	Is it at the time of admission?		2.01
2.02	Is it at the time of first billing?		2.02
2.03	Is it after some collection effort has been made?		2.03
2.04	Other methods of write-offs (specify)		2.04
3	Are charity write-offs made for partial bills?		3
4	Are charity determinations based upon administrative judgment without financial data?		4
5	Are charity determinations based upon income data only?		5
6	Are charity determinations based upon net worth (assets) data?		6
7	Are charity determinations based upon income and net worth data?		7
8	Does your accounting system separately identify bad debt and charity care? If yes answer 8.01		8
8.01	Do you separately account for inpatient and outpatient services?		8.01
9	Is discerning charity from bad debt a high priority in your institution? If no answer 9.01 thru 9.04		9
9.01	Is it because there is not enough staff to determine eligibility?		9.01
9.02	Is it because there is no financial incentive to separate charity from bad debt?		9.02
9.03	Is it because there is no clear directive policy on charity determination?		9.03
9.04	Is it because your institution does not deem the distinction important?		9.04
10	If charity determinations are made based upon income data, what is the maximum income that can be earned by patients (single without dependent) and still determined to be a charity write off??		10
11	If charity determinations are made based upon income data, is the income directly tied to Federal poverty level? If yes answer lines 11.01 thru 11.04		11
11.01	Is the percentage level used less than 100% of the Federal poverty level?		11.01
11.02	Is the percentage level used between 100% and 150% of the Federal poverty level?		11.02
11.03	Is the percentage level used between 150% and 200% of the Federal poverty level?		11.03
11.04	Is the percentage level greater than or equal to 200% of the Federal poverty level?		11.04
12	Are partial write-offs given to higher income patients on a gradual scale?		12
13	Is there charity consideration given to high net worth patients who have catastrophic or other extraordinary medical expenses?		13
14	Is your hospital State or local government owned? If yes answer line 14.01 and 14.02		14
14.01	Do you receive direct financial support from the government entity for the purpose of providing uncompensated care?		14.01
14.02	What percentage of the amount on line 14.01 is from government funding?		14.02
15	Do you receive restricted grants for rendering care to charity patients?		15
16	Are other non-restricted grants used to subsidize charity care?		16
Uncompensated Care Revenues			
17	Revenues from uncompensated care	3,509,773	17
17.01	Gross Medicaid Revenues	6,248,034	17.01
18	Revenues from State and local indigent care programs	6,089,089	18
19	Revenues related to SCHIP (see instructions)		19
20	Restricted grants	5,134	20
21	Non-restricted grants		21
22	Total Gross Uncompensated Care Revenues	15,852,030	22
Uncompensated Care Costs			
23	Total charges for patients covered by State and local indigent care programs	2,965,419	23
24	Cost to Charge Ratio (Wkst C, Part I, column 3 line 103, divided by column 8, line 103)	0.250338	24
25	Total State and local indigent care program cost (line 23 x line 24)	742,357	25
26	Total SCHIP charges from your records		26
27	Total SCHIP cost, (line 24 x line 26)		27
28	Total gross Medicaid charges from your records	21,881,969	28
29	Total gross Medicaid cost (line 24 x line 28)	5,477,888	29
30	Other uncompensated care charges from your records (see instructions)	51,248,821	30
31	Uncompensated care cost (line 24 x line 30)	12,829,527	31
32	Total uncompensated cost to the hospital (Sum of lines 25, 27, and 29)	6,220,245	32

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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES			PROVIDER NO: 420065		PERIOD: FROM 01/01/2010 TO 12/31/2010			WORKSHEET A	
		COST CENTER DESCRIPTIONS (omit cents)	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	RECLASSIFIED TRIAL BALANCE (col. 3 + col. 4)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 5 + col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	0100	Old Capital Related Costs-Buildings and Fixtures								1
2	0200	Old Capital Related Costs-Movable Equipment								2
3	0300	New Capital Related Costs-Buildings and Fixtures		7,736,878	7,736,878	-3,071,352	4,665,526	5,236,197	9,901,723	3
4	0400	New Capital Related Costs-Movable Equipment		409,318	409,318	3,071,352	3,480,670	1,706,985	5,187,655	4
5	0500	Employee Benefits	563	10,763,901	10,764,464		10,764,464	32,829	10,797,293	5
6.05	0600	Administrative & General	4,965,691	23,137,285	28,102,976	25,074	28,128,050	-6,019,284	22,108,766	6.05
7	0700	Maintenance and Repairs								7
8	0800	Operation of Plant	763,883	4,848,454	5,612,337		5,612,337		5,612,337	8
9	0900	Laundry and Linen Service		579,851	579,851		579,851		579,851	9
10	01000	Housekeeping	1,235,446	338,110	1,573,556		1,573,556		1,573,556	10
11	1100	Dietary	1,161,481	1,298,005	2,459,486		2,459,486		2,459,486	11
12	1200	Cafeteria						-923,486	-923,486	12
13	1300	Maintenance of Personnel								13
14	1400	Nursing Administration	732,857	164,723	897,580		897,580		897,580	14
15	1500	Central Services and Supply								15
16	1600	Pharmacy								16
17	1700	Medical Records & Medical Records Library	167,473	14,611	182,084		182,084	-1,198	180,886	17
18	1800	Social Service								18
19.00	1900	Other General Service (specify)								19.00
20	2000	Nonphysician Anesthetics								20
21	2100	Nursing School								21
22	2200	Intern & Res Service-Salary & Fringes (Approved)								22
23	2300	Intern & Res. Other Program Costs (Approved)								23
24	2400	Paramedical Ed Program (specify)	153,549	4,173	157,722	-25,074	132,648	-3,688	128,960	24
		INPATIENT ROUTINE SERVICE COST CENTERS								
25	2500	Adults and Pediatrics (General Routine Care)	14,683,777	1,746,076	16,429,853	-1,894,041	14,535,812	-6,531	14,529,281	25
26	2600	Intensive Care Unit	1,912,577	294,723	2,207,300		2,207,300	-522	2,206,778	26
27	2700	Coronary Care Unit								27
28	2800	Burn Intensive Care Unit								28
29	2900	Surgical Intensive Care Unit								29
30.00	3000	Other Special Care (specify)								30.00
31.00	3100	Subprovider								31.00
33	3300	Nursery	2,151,989	557,021	2,709,010		2,709,010	-871,499	1,837,511	33
34	3400	Skilled Nursing Facility								34

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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES			PROVIDER NO: 420065			PERIOD: FROM 01/01/2010 TO 12/31/2010		WORKSHEET A	
COST CENTER DESCRIPTIONS (omit cents)			SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	RECLASSIFIED TRIAL BALANCE (col. 3 + col. 4)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 5 - col. 6)	
			1	2	3	4	5	6	7	
35.00	3500	Nursing Facility								35.00
36	3600	Other Long Term Care								36
		ANCILLARY SERVICE COST CENTERS								
37.05	3700	Operating Room	5,034,007	7,845,449	12,879,456		12,879,456	-1,542,689	11,336,767	37.05
38	3800	Recovery Room	665,911	24,936	690,847		690,847		690,847	38
39.05	3900	Delivery Room & Labor Room	86,431	39,103	125,534	1,894,041	2,019,575	-41,694	1,977,881	39.05
40.00	4000	Anesthesiology								40.00
41.05	4100	Radiology-Diagnostic	3,777,916	1,395,977	5,173,893		5,173,893	-326,993	4,846,900	41.05
42.00	4200	Radiology-Therapeutic								42.00
43	4300	Radioisotope								43
44.05	4400	Laboratory	1,415,682	2,134,917	3,550,599		3,550,599	-196,860	3,353,739	44.05
44.10	4400	Oncology	290,875	54,378	345,253		345,253		345,253	44.10
44.45	4400	Vascular Lab	221,938	3,955	225,893		225,893		225,893	44.45
45	4500	PBP Clinical Laboratory Services-Program Only								45
46.00	4600	Whole Blood & Packed Red Blood Cells								46.00
47	4700	Blood Storing, Processing, & Trans.	152,258	981,658	1,133,916		1,133,916	-382	1,133,534	47
48	4800	Intravenous Therapy								48
49.05	4900	Respiratory Therapy	856,830	150,100	1,006,930		1,006,930		1,006,930	49.05
50.05	5000	Physical Therapy	1,712,788	58,972	1,771,760		1,771,760	-430	1,771,330	50.05
51	5100	Occupational Therapy								51
52	5200	Speech Pathology								52
53.05	5300	Electrocardiology	371,999	51,042	423,041		423,041	-42,946	380,095	53.05
54	5400	Electroencephalography								54
55	5500	Medical Supplies Charged to Patients								55
55.30	5530	Implantable Devices Charged to Patients		6,844,600	6,844,600		6,844,600		6,844,600	55.30
56	5600	Drugs Charged to Patients	2,231,016	7,228,769	9,459,785		9,459,785	-7,596	9,452,189	56
57	5700	Renal Dialysis								57
58	5800	ASC (Non-Distinct Part)								58
59.30	5900	Other Ancillary Cost Centers	169,740	531,058	700,798		700,798	-344,571	356,227	59.30
		OUTPATIENT SERVICE COST CENTERS								
60.00	6000	Clinic								60.00
61	6100	Emergency	3,813,675	652,027	4,465,702		4,465,702		4,465,702	61
62.00	6200	Observation Beds								62.00
63.00		Other Outpatient Service (specify)								63.00
		OTHER REIMBURSABLE COST CENTERS								
64	6400	Home Program Dialysis								64
65	6500	Ambulance Services								65

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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES			PROVIDER NO: 420065		PERIOD: FROM 01/01/2010 TO 12/31/2010		WORKSHEET A		
		COST CENTER DESCRIPTIONS (omit cents)	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	RECLASSIFIED TRIAL BALANCE (col. 3 + col. 4)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 5 + col. 6)	
			1	2	3	4	5	6	7	
66.00	6600	Durable Medical Equipment-Rented								66.00
67.00	6700	Durable Medical Equipment-Sold								67.00
68	6800	Other Reimbursable (specify)								68
69.00	6900	Outpatient Rehabilitation Provider (specify)								69.00
70	7000	Intern-Resident Service (not appvd. tchng. prgm.)								70
71	7100	Home Health Agency								71
		SPECIAL PURPOSE COST CENTERS								
82	8200	Lung Acquisition								82
83	8300	Kidney Acquisition								83
84	8400	Livery Acquisition								84
85.00	8500	Heart Acquisition								85.00
86	8600	Other Organ Acquisition (specify)								86
88	8800	Interest Expense								88
89	8900	Utilization Review-SNF								89
90	9000	Other Capital-Related Costs (see instructions)								90
92	9200	Ambulatory Surgical Center (Distinct Part)								92
93	9300	Hospice								93
94	9400	Other Special Purpose (specify)								94
95		SUBTOTALS (sum of lines 1-94)	48,730,352	79,890,070	128,620,422		128,620,422	-3,354,358	125,266,064	95
		NONREIMBURSABLE COST CENTERS								
96	9600	Gift, Flower, Coffee Shop, & Canteen	22,108	68,170	90,278		90,278	-50,526	39,752	96
97	9700	Research								97
98	9800	Physicians' Private Offices								98
99	9900	Nonpaid Workers								99
100		Other Nonreimbursable (specify)	298,109	71,202	369,311		369,311	-114,244	255,067	100
101		TOTAL (sum of lines 95-100)	49,050,569	80,029,442	129,080,011		129,080,011	-3,519,128	125,560,883	101

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ANALYSIS OF CHANGES DURING COST REPORTING PERIOD IN CAPITAL ASSET BALANCES OF HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX CERTIFIED TO PARTICIPATE IN HEALTH CARE PROGRAMS	PROVIDER NO. 420065	PERIOD. FROM 01/01/2010 TO 12/31/2010	WORKSHEET A7 Parts 1 & 2	

PART I - ANALYSIS OF CHANGES IN OLD CAPITAL ASSET BALANCES

	Description	Beginning Balances	Acquisitions			Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
			Purchases	Donation	Total				
		1	2	3	4	5	6	7	
1	Land								1
2	Land Improvements								2
3	Buildings and Fixtures								3
4	Building Improvements								4
5	Fixed Equipment								5
6	Movable Equipment								6
7	Subtotal (sum of lines 1-6)								7
8	Reconciling Items								8
9	Total (line 7 minus line 8)								9

PART II - ANALYSIS OF CHANGES IN NEW CAPITAL ASSET BALANCES

	Description	Beginning Balances	Acquisitions			Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
			Purchases	Donation	Total				
		1	2	3	4	5	6	7	
1	Land	13,685,043				104,100	13,580,943		1
2	Land Improvements	2,476,119	748,789		748,789	2,332	3,222,576		2
3	Buildings and Fixtures	82,526,377	17,441,120		17,441,120		99,967,497		3
4	Building Improvements	15,552,193	1,918,979		1,918,979	2,710	17,468,462		4
5	Fixed Equipment	4,902,454	4,965		4,965	21,857	4,885,562		5
6	Movable Equipment	35,846,822	4,898,468		4,898,468	1,696,822	39,048,468		6
7	Subtotal (sum of lines 1-6)	154,989,008	25,012,321		25,012,321	1,827,821	178,173,508		7
8	Reconciling Items								8
9	Total (line 7 minus line 8)	154,989,008	25,012,321		25,012,321	1,827,821	178,173,508		9

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RECONCILIATION OF CAPITAL COSTS CENTERS	PROVIDER NO: 420065	PERIOD: FROM 01/01/2010 TO 12/31/2010	WORKSHEET A7, PARTS III & IV

PART III - RECONCILIATION OF CAPITAL COSTS CENTERS

Description		COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instru.)	Insurance	Taxes	Other Capital-Related Costs	Total (sum of cols. 5-7)	
		1	2	3	4	5	6	7	8	
1	Old Capital Related Costs-Buildings and Fixtures									1
2	Old Capital Related Costs-Movable Equipment									2
3	New Capital Related Costs-Buildings and Fixtures									3
4	New Capital Related Costs-Movable Equipment									4
5	Total (sum of lines 1-4)									5

Description *		SUMMARY OF OLD AND NEW CAPITAL							
		Depreciation	Lease	Interest	Insurance (see instru.)	Taxes (see instru.)	Other Capital-Related Costs (see instru.)	Total (1) (sum of cols. 9-14)	
		9	10	11	12	13	14	15	
1	Old Capital Related Costs-Buildings and Fixtures								1
2	Old Capital Related Costs-Movable Equipment								2
3	New Capital Related Costs-Buildings and Fixtures	9,745,769	155,954					9,901,723	3
4	New Capital Related Costs-Movable Equipment	4,778,337	409,318					5,187,655	4
5	Total (sum of lines 1-4)	14,524,106	565,272					15,089,378	5

(1) The amounts on lines 1 thru 4 must equal the corresponding amounts on Worksheet A, column 7, lines 1 thru 4. Columns 9 through 14 should include related Worksheet A-6 reclassifications, Worksheet A-8 adjustments, and Worksheet A-8-1 related organizations and home office costs. (See instructions.)

PART IV - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 THRU 4

Description *		SUMMARY OF OLD AND NEW CAPITAL							
		Depreciation	Lease	Interest	Insurance (see instru.)	Taxes (see instru.)	Other Capital-Related Costs (see instru.)	Total (1) (sum of cols. 9-14)	
		9	10	11	12	13	14	15	
1	Old Capital Related Costs-Buildings and Fixtures								1
2	Old Capital Related Costs-Movable Equipment								2
3	New Capital Related Costs-Buildings and Fixtures	7,580,924	155,954					7,736,878	3
4	New Capital Related Costs-Movable Equipment		409,318					409,318	4
5	Total (sum of lines 1-4)	7,580,924	565,272					8,146,196	5

(1) The amount in columns 9 thru 14 must equal the amount on Worksheet A, column 2, lines 1 thru 4. Enter in each column the appropriate amounts including any directly assigned cost which may have been included in Worksheet A, column 2, lines 1 thru 4. All lines numbers except line 5 are to be consistent with Worksheet A line numbers for capital cost centers.

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	ADJUSTMENTS TO EXPENSES	PROVIDER NO: 420065	PERIOD: FROM: 01/01/2010 TO: 12/31/2010	WORKSHEET A-8			
	DESCRIPTION (1)	(2)		Epense Classification on Worksheet A to/from which the amount is to be adjusted		Wkst. A-7 Ref.	
		BASIS/CODE	AMOUNT	COST CENTER		LINE #	
		1	2	3	4	5	
1	Investment income - old buildings and fixtures (chapter 2)			Old Buildings and Fixtures			1
2	Investment income - old movable equipment (chapter 2)			Old Moveble Equipment	2		2
3	Investment income - new buildings and fixtures (chapter 2)			New Buildings and Fixtures	3		3
4	Investment income - new movable equipment (chapter 2)			New Movable Equipment	4		4
5	Investment income - other (chapter 2)						5
6	Trade, quantity, and time discounts (chapter 8)						6
7	Refunds and rebates of expenses (chapter 8)						7
8	Rental of provider space by suppliers (chapter 8)						8
9	Telephone services (pay stations excluded) (chapter 21)						9
10	Television and radio service (chapter 21)						10
11	Parking lot (chapter 21)						11
12	Provider-based physician adjustment	Wkst A-8-2					12
13	Sale of scrap, waste, etc. (chapter 23)						13
14	Related organization transactions (chapter 10)	Wkst A-8-1	2,722,364				14
15	Laundry and linen service						15
16	Cafeteria-employees and guests						16
17	Rental of quarters to employee and others						17
18	Sale of medical and surgical supplies to other than patients						18
19	Sale of drugs to other than patients						19
20	Sale of medical records and abstracts						20
21	Nursing school (tuition, fees, books, etc.)						21
22	Vending machines						22
23	Income from imposition of interest, finance or penalty charges (chapter 21)						23
24	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments						24
25	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	Wkst A-8-3 Wkst A-8-4		Respiratory Therapy	25		25
26	Adjustment for physical therapy costs in excess of limitation (chapter 14)	Wkst A-8-3 Wkst A-8-4		Physical Therapy	30		26
27	Adjustment for HHA physical therapy costs in excess of limitation	Wkst A-8-3		HHA	71		27
28	Utilization review - physicians' compensation (chapter 21)			Utilization Review - SNF	89		28
29	Depreciation - old buildings and fixtures			Old Buildings and Fixtures			29
30	Depreciation - old movable equipment			Old Moveble Equipment	2		30
31	Depreciation - new buildings and fixtures			New Buildings and Fixtures	3		31
32	Depreciation - new movable equipment			New Movable Equipment	4		32
33	Non-physician Anesthetist			Non-physician Anesthetist	20		33
34	Physicians' assistant						34
35	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Occupational Therapy	21		35
36	Adjustment for speech pathology costs in excess of limitation (chapter 14)	Wkst A-8-3		Speech Pathology	52		36
37	Other adjustments (specify) (3)		-6,241,492				37
50	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 101.)		-3,519,128				50

(1) Description - all chapter references in this column pertain to HCFA Pub. 15-1. (2) Basis for adjustment (see instructions). A. Costs - if cost, including applicable overhead, can be determined. B. Amount Received - if cost cannot be determined. (3) Additional adjustments may be made on lines 37 thru 49 and subscripts thereof. Note:See instructions for column 5 referencing to Worksheet A-7.

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Statement of Costs of Services from Related Organizations and Home Office Costs				PROVIDER NO: 420065	PERIOD: FROM: 01/01/2010 TO: 12/31/2010		WORKSHEET A-8-1 Part A	
A. Costs incurred and adjustments required as a result of transactions with related organizations or the claiming of home office costs:								
	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount included in Wkst. A, column 5	Net Adjustments (col.4 - col.5) *	Wkst. A-7 Ref.	
	1	2	3	4	5	6	7	
1	5		CONTRA EMPLOYEE BENEFITS	8,194,462	7,989,686	204,776		1
2	6		CORP ALLOCATION EXPENSE	7,141,376	17,268,881	-10,127,505		2
3	6		HOME OFFICE SALARIES	5,991,873		5,991,873		3
4.00	3		CRC-BLDG & FIX NEW	5,290,806		5,290,806	9	4.00
4.01	4		CRC-MME NEW	37,034		37,034	9	4.01
4.02	4		SHARED NEW CRC	1,669,951		1,669,951	9	4.02
4.03	44		INTERCO LAB SVCS	324,223	324,223			4.03
4.04	56		PURCHASED SERVICES OTHER	183,024	527,595	-344,571		4.04
4.05	6		CONTRA SUPPORT FROM FOUND	-5,484	-5,484			4.05
4.06	8		CONTRA SUPPORT FROM FOUND	-8,132	-8,132			4.06
4.07	14		CONTRA SUPPORT FROM FOUND	-100	-100			4.07
4.08	25		CONTRA SUPPORT FROM FOUND	-8,000	-8,000			4.08
4.09	33		CONTRA SUPPORT FROM FOUND	-14,917	-14,917			4.09
4.10	37		CONTRA SUPPORT FROM FOUND	-1,000	-1,000			4.10
4.11	61		CONTRA SUPPORT FROM FOUND	-21,394	-21,394			4.11
5	TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet A-8, column 2, line 14.			28,773,722	26,051,358	2,722,364		5
	*The amounts on lines 1-4 and subscripts as appropriate are transfered in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost.For related organizational or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.							

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Statement of Costs of Services from Related Organizations and Home Office Costs	PROVIDER NO: 420065	PERIOD: FROM: 01/01/2010 TO: 12/31/2010	WORKSHEET A-8-1 Part B

B. Interrelationship to related organization(s) and/or home office:

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet. This information is used by the Health Care Financing Administration and its intermediaries in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act.If you do not provide all or any part of the requested information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

				Related Organization(s) and/or Home Office			
	Symbol (1)	Name	Percentage of Ownership		Percentage of Ownership	Type of Business	
	1	2	3	4	5	6	
1	B			CAREALLIANCE HEALTH SERVI		CORPORATE OFFICE	1
2	B			ROPER HOSPITAL		SHARE STAFF AND SERVICES	2
3							3
4							4

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

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

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COST ALLOCATION - GENERAL SERVICE COSTS							PROVIDER NO.: 420065		PERIOD: FROM 01/01/2010 TO 12/31/2010		WORKSHEET B, PART I	
COST CENTER DESCRIPTIONS		NET EXPENSES FOR COST ALLOCATION (from Wkst. A, col. 7)	OLD CAPITAL RELATED COSTS		NEW CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	SUBTOTAL (cols. 0-5)	ADMINIS-TRATIVE & GENERAL	MAIN-TENANCE & REPAIRS	OPERATION OF PLANT	
			BLDGS. & FIXTURES	MOVABLE EQUIPMENT	BLDGS. & FIXTURES	MOVABLE EQUIPMENT						
		0	1	2	3	4	5	5a	6	7	8	
	GENERAL SERVICE COST CENTERS											
1	Old Capital Related Costs-Buildings and Fixtures											1
2	Old Capital Related Costs-Movable Equipment											2
3	New Capital Related Costs-Buildings and Fixtures	9,901,723			9,901,723							3
4	New Capital Related Costs-Movable Equipment	5,187,655				5,187,655						4
5	Employee Benefits	10,797,293			57,094		10,854,387					5
6.05	Administrative & General	22,108,766			700,202	30,141	1,064,070	23,903,179	23,903,179			6.05
7	Maintenance and Repairs											7
8	Operation of Plant	5,612,337			2,081,576	354,204	172,068	8,220,185	1,915,443		10,135,628	8
9	Laundry and Linen Service	579,851			58,644			638,495	148,780		84,158	9
10	Housekeeping	1,573,556			78,078	14,364	278,290	1,944,288	453,052		112,046	10
11	Dietary	2,459,486			282,888	27,330	261,629	3,031,333	706,352		405,962	11
12	Cafeteria	-923,486						-923,486				12
13	Maintenance of Personnel											13
14	Nursing Administration	897,580			28,074	25,737	165,080	1,116,471	260,157		40,287	14
15	Central Services and Supply											15
16	Pharmacy											16
17	Medical Records and Medical Records Library	180,886			128,742	4,463	37,724	351,815	81,979		184,753	17
18	Social Service											18
19.00	Other General Service (specify)											19.00
20	Nonphysician Anesthetists											20
21	Nursing School											21
22	Intern &Res. Service-Salary &Fringes (Approved)											22
23	Intern &Res. Other Program Costs (Approved)											23
24	Paramedical Ed. Program (specify)	128,960			14,037		28,940	171,937	40,064		20,144	24
	INPATIENT ROUTINE SERVICE COST CENTERS											
25	Adults and Pediatrics (General Routine Care)	14,529,281			2,948,985	535,013	2,949,869	20,963,148	4,884,788		4,231,977	25
26	Intensive Care Unit	2,206,778			160,949	44,296	428,588	2,840,611	661,911		230,972	26

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COST ALLOCATION - GENERAL SERVICE COSTS							PROVIDER NO.: 420065		PERIOD: FROM 01/01/2010 TO 12/31/2010		WORKSHEET B, PART I	
COST CENTER DESCRIPTIONS		NET EXPENSES FOR COST ALLOCATION (from Wksht. A, col. 7)	OLD CAPITAL RELATED COSTS		NEW CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	SUBTOTAL (cols. 0-5)	ADMINIS-TRATIVE & GENERAL	MAIN-TENANCE & REPAIRS	OPERATION OF PLANT	
			BLDGS. & FIXTURES	MOVABLE EQUIPMENT	BLDGS. & FIXTURES	MOVABLE EQUIPMENT						
		0	1	2	3	4	5	5a	6	7	8	
27	Coronary Care Unit											27
28	Burn Intensive Care Unit											28
29	Surgical Intensive Care Unit											29
30.00	Other Special Care (specify)											30.00
31.00	Subprovider											31.00
33	Nursery	1,837,511			148,262	114,494	367,793	2,468,060	575,100		212,765	33
34	Skilled Nursery Facility											34
35.00	Nursing Facility											35.00
36	Other Long Term Care											36
	ANCILLARY SERVICE COST CENTERS											
37.05	Operating Room	11,336,767			1,145,992	1,572,258	1,133,935	15,188,952	3,539,284		1,644,569	37.05
38	Recovery Room	690,847			95,961	83,779	150,000	1,020,587	237,814		137,710	38
39.05	Delivery Room & Labor Room	1,977,881			71,447	67,171	375,715	2,492,214	580,728		102,531	39.05
40.00	Anesthesiology											40.00
41.05	Radiology-Diagnostic	4,846,900			370,439	1,693,359	850,994	7,761,692	1,808,606		531,603	41.05
42.00	Radiology-Therapeutic											42.00
43	Radioisotope											43
44.05	Laboratory	3,353,739			160,318	84,330	318,889	3,917,276	912,792		230,066	44.05
44.10	Oncology	345,253			149,439	2,577	65,521	562,790	131,140		214,454	44.10
44.45	Vascular Lab	225,893			8,554	104,877	49,993	389,317	90,717		12,276	44.45
45	PBP Clinical Laboratory Services-Program Only											45
46.00	Whole Blood & Packed Red Blood Cells											46.00
47	Blood Storing, Processing, & Trans.	1,133,534			11,166	1,434	34,297	1,180,431	275,060		16,024	47
48	Intravenous Therapy											48
49.05	Respiratory Therapy	1,006,930			36,341	34,949	193,005	1,271,225	296,217		52,151	49.05
50.05	Physical Therapy	1,771,330			340,987	19,080	385,814	2,517,211	586,553		489,338	50.05
51	Occupational Therapy											51
52	Speech Pathology											52
53.05	Electrocardiology	380,095			48,655	48,057	80,731	557,538	129,916		69,823	53.05
54	Electroencephalography											54

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COST ALLOCATION - GENERAL SERVICE COSTS							PROVIDER NO.: 420065		PERIOD: FROM 01/01/2010 TO 12/31/2010		WORKSHEET B, PART I	
COST CENTER DESCRIPTIONS		NET EXPENSES FOR COST ALLOCATION (from Wksht. A, col. 7)	OLD CAPITAL RELATED COSTS		NEW CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	SUBTOTAL (cols. 0-5)	ADMINIS-TRATIVE & GENERAL	MAIN-TENANCE & REPAIRS	OPERATION OF PLANT	
			BLDGS. & FIXTURES	MOVABLE EQUIPMENT	BLDGS. & FIXTURES	MOVABLE EQUIPMENT						
		0	1	2	3	4	5	5a	6	7	8	
55	Medical Supplies Charged to Patients											55
55.30	Implantable Devices Charged to Patients	6,844,600						6,844,600	1,594,908			55.30
56	Drugs Charged to Patients	9,452,189			129,747	105,354	502,548	10,189,838	2,374,405		186,195	56
57	Renal Dialysis											57
58	ASAC (Non-Distinct Part)											58
59.30	Other Ancillary Cost Centers	356,227			51,497	793	38,235	446,752	104,101		73,901	59.30
	OUTPATIENT SERVICE COST CENTERS											
60.00	Clinic											60.00
61	Emergency	4,465,702			522,891	215,965	859,049	6,063,607	1,412,924		750,381	61
62.00	Observation Beds											62.00
63.00	Other Outpatient Service (specify)											63.00
	OTHER REIMBURSABLE COST CENTERS											
64	Home Program Dialysis											64
65	Ambulance Services											65
66.00	Durable Medical Equipment-Rented											66.00
67.00	Durable Medical Equipment-Sold											67.00
68	Other Reimbursable (specify)											68
69.00	Outpatient Rehabilitation Provider (specify)											69.00
70	Intern-Resident Service (not apprvd. tchng. prgm.)											70
71	Home Health Agency											71
	SPECIAL PURPOSE COST CENTERS											
82	Lung Acquisition											82
83	Kidney Acquisition											83
84	Liver Acquisition											84
85.00	Heart Acquisition											85.00
86	Other Organ Acquisition (specify)											86
92	Ambulatory Surgical Center (Distinct Part)											92
93	Hospice											93
94	Other Special Purpose (specify)											94
95	SUBTOTALS (sum of lines 1-94)	125,266,064			9,830,965	5,184,025	10,792,777	125,130,066	23,802,791		10,034,086	95

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COST ALLOCATION - GENERAL SERVICE COSTS							PROVIDER NO.: 420065		PERIOD: FROM 01/01/2010 TO 12/31/2010		WORKSHEET B, PART I	
COST CENTER DESCRIPTIONS		NET EXPENSES FOR COST ALLOCATION (from Wkst. A, col. 7)	OLD CAPITAL RELATED COSTS		NEW CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	SUBTOTAL (cols. 0-5)	ADMINIS-TRATIVE & GENERAL	MAIN-TENANCE & REPAIRS	OPERATION OF PLANT	
			BLDGS. & FIXTURES	MOVABLE EQUIPMENT	BLDGS. & FIXTURES	MOVABLE EQUIPMENT						
		0	1	2	3	4	5	5a	6	7	8	
	NONREIMBURSABLE COST CENTERS											
96	Gift, Flower, Coffee Shop, &Canteen	39,752			70,758	3,630	4,980	119,120	27,757		101,542	96
97	Research											97
98	Physicians' Private Offices											98
99	Nonpaid Workers											99
100	Other Nonreimbursable (specify)	255,067					56,630	311,697	72,631			100
101	Cross Foot Adjustments											101
102	Negative Cost Centers											102
103	Total (sum of lines 95-102)	125,560,883			9,901,723	5,187,655	10,854,387	125,560,883	23,903,179		10,135,628	103

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COST ALLOCATION - GENERAL SERVICE COSTS					PROVIDER NO.: 420065		PERIOD: FROM 01/01/2010 TO 12/31/2010		WORKSHEET B. PART I			
COST CENTER DESCRIPTIONS		LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	MAIN-TENANCE OF PERSONNEL	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & MEDICAL LIBRARY	SOCIAL SERVICE	
		9	10	11	12	13	14	15	16	17	18	
	GENERAL SERVICE COST CENTERS											
1	Old Capital Related Costs-Buildings and Fixtures											1
2	Old Capital Related Costs-Movable Equipment											2
3	New Capital Related Costs-Buildings and Fixtures											3
4	New Capital Related Costs-Movable Equipment											4
5	Employee Benefits											5
6 05	Administrative & General											6.05
7	Maintenance and Repairs											7
8	Operation of Plant											8
9	Laundry and Linen Service	871,423										9
10	Housekeeping		2,509,386									10
11	Dietary	102,492	4,246,139									11
12	Cafeteria			2,698,077	1,774,591							12
13	Maintenance of Personnel											13
14	Nursing Administration		10,171		24,824		1,451,910					14
15	Central Services and Supply											15
16	Pharmacy											16
17	Medical Records and Medical Records Library		46,644		14,684					679,875		17
18	Social Service											18
19.00	Other General Service (specify)											19.00
20	Nonphysician Anesthetists											20
21	Nursing School											21
22	Intern &Res. Service-Salary &Fringes (Approved)											22
23	Intern &Res. Other Program Costs (Approved)											23
24	Paramedical Ed. Program (specify)		5,086		9,627							24
	INPATIENT ROUTINE SERVICE COST CENTERS											
25	Adults and Pediatrics (General Routine Care)	391,749	1,068,440	637,384	583,905		684,757			182,229		25
26	Intensive Care Unit	33,471	58,313	79,884	73,547		86,249			33,708		26

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COST ALLOCATION - GENERAL SERVICE COSTS					PROVIDER NO.: 420065		PERIOD: FROM 01/01/2010 TO 12/31/2010		WORKSHEET B. PART I			
COST CENTER DESCRIPTIONS		LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	MAIN-TENANCE OF PERSONNEL	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & MEDICAL LIBRARY	SOCIAL SERVICE	
		9	10	11	12	13	14	15	16	17	18	
27	Coronary Care Unit											27
28	Burn Intensive Care Unit											28
29	Surgical Intensive Care Unit											29
30 00	Other Special Care (specify)											30 00
31.00	Subprovider											31.00
33	Nursery	21,423	53,716		67,925		79,657			24,636		33
34	Skilled Nursery Facility											34
35 00	Nursing Facility											35 00
36	Other Long Term Care											36
	ANCILLARY SERVICE COST CENTERS											
37.05	Operating Room	149,121	415,201		245,566		287,980			224,817		37.05
38	Recovery Room	10,629	34,767		25,311		29,683					38
39.05	Delivery Room & Labor Room	39,899	25,886		63,484		74,448					39.05
40 00	Anesthesiology											40 00
41.05	Radiology-Diagnostic	53,690	134,213		171,788					8,914		41.05
42.00	Radiology-Therapeutic											42.00
43	Radioisotope											43
44.05	Laboratory		58,084		79,605							44.05
44.10	Oncology	3,998	54,143		12,245							44.10
44 45	Vascular Lab	17,484	3,099		8,600							44 45
45	PBP Clinical Laboratory Services-Program Only											45
46.00	Whole Blood & Packed Red Blood Cells											46.00
47	Blood Storing, Processing, & Trans.		4,046		7,316							47
48	Intravenous Therapy											48
49 05	Respiratory Therapy		13,166		35,374							49 05
50.05	Physical Therapy	21,050	123,542		72,648							50 05
51	Occupational Therapy											51
52	Speech Pathology											52
53.05	Electrocardiology		17,628		18,149							53 05
54	Electroencephalography											54

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COST ALLOCATION - GENERAL SERVICE COSTS					PROVIDER NO.: 420065		PERIOD: FROM 01/01/2010 TO 12/31/2010		WORKSHEET B. PART I			
COST CENTER DESCRIPTIONS		LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	MAIN-TENANCE OF PERSONNEL	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & MEDICAL LIBRARY	SOCIAL SERVICE	
		9	10	11	12	13	14	15	16	17	18	
55	Medical Supplies Charged to Patients											55
55.30	Implantable Devices Charged to Patients											55.30
56	Drugs Charged to Patients		47,008		59,890							56
57	Renal Dialysis											57
58	ASAC (Non-Distinct Part)											58
59.30	Other Ancillary Cost Centers		18,658		8,651							59.30
	OUTPATIENT SERVICE COST CENTERS											
60.00	Clinic											60.00
61	Emergency	128,919	189,447		178,334		209,136			205,571		61
62.00	Observation Beds											62.00
63.00	Other Outpatient Service (specify)											63.00
	OTHER REIMBURSABLE COST CENTERS											
64	Home Program Dialysis											64
65	Ambulance Services											65
66.00	Durable Medical Equipment-Rented											66.00
67.00	Durable Medical Equipment-Sold											67.00
68	Other Reimbursable (specify)											68
69.00	Outpatient Rehabilitation Provider (specify)											69.00
70	Intern-Resident Service (not apprvd. tchng. prgm.)											70
71	Home Health Agency											71
	SPECIAL PURPOSE COST CENTERS											
82	Lung Acquisition											82
83	Kidney Acquisition											83
84	Liver Acquisition											84
85.00	Heart Acquisition											85.00
86	Other Organ Acquisition (specify)											86
92	Ambulatory Surgical Center (Distinct Part)											92
93	Hospice											93
94	Other Special Purpose (specify)											94
95	SUBTOTALS (sum of lines 1-94)	871,433	2,483,750	3,415,345	1,761,473		1,451,910			679,875		95

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COST ALLOCATION - GENERAL SERVICE COSTS					PROVIDER NO.: 420065		PERIOD: FROM 01/01/2010 TO 12/31/2010		WORKSHEET B. PART I			
COST CENTER DESCRIPTIONS		LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	MAIN-TENANCE OF PERSONNEL	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & MEDICAL LIBRARY	SOCIAL SERVICE	
		9	10	11	12	13	14	15	16	17	18	
	NONREIMBURSABLE COST CENTERS											
96	Gift, Flower, Coffee Shop, &Canteen		25,636	830,794	1,669							96
97	Research											97
98	Physicians' Private Offices											98
99	Nonpaid Workers											99
100	Other Nonreimbursable (specify)				11,449							100
101	Cross Foot Adjustments											101
102	Negative Cost Centers											102
103	Total (sum of lines 95-102)	871,433	2,509,386	4,246,139	1,774,591		1,451,910			679,875		103

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Cost report status - As Submitted
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COST ALLOCATION - GENERAL SERVICE COSTS						PROVIDER NO.: 420065		PERIOD: FROM 01/01/2010 TO 12/31/2010		WORKSHEET B. PART I	
COST CENTER DESCRIPTIONS		OTHER GENERAL SERVICE	NON-PHYSICIAN ANES-THETISTS	NURSING SCHOOL	INTERNS & RESIDENTS SALARY & FRINGES	INTERNS & RESIDENTS PROGRAM COSTS	PARA-MEDICAL EDUCATION (SPECIFY)	SUBTOTAL	INTERN & RESIDENT COST &POST STEPDOWN ADJUSTMENTS	TOTAL	
		19	20	21	22	23	24	25	26	27	
	GENERAL SERVICE COST CENTERS										
1	Old Capital Related Costs-Buildings and Fixtures										1
2	Old Capital Related Costs-Movable Equipment										2
3	New Capital Related Costs-Buildings and Fixtures										3
4	New Capital Related Costs-Movable Equipment										4
5	Employee Benefits										5
6.05	Administrative & General										6.05
7	Maintenance and Repairs										7
8	Operation of Plant										8
9	Laundry and Linen Service										9
10	Housekeeping										10
11	Dietary										11
12	Cafeteria										12
13	Maintenance of Personnel										13
14	Nursing Administration										14
15	Central Services and Supply										15
16	Pharmacy										16
17	Medical Records and Medical Records Library										17
18	Social Service										18
19.00	Other General Service (specify)										19.00
20	Nonphysician Anesthetists										20
21	Nursing School										21
22	Intern &Res. Service-Salary &Fringes (Approved)										22
23	Intern &Res. Other Program Costs (Approved)										23
24	Paramedical Ed. Program (specify)									246,858	24
	INPATIENT ROUTINE SERVICE COST CENTERS										
25	Adults and Pediatrics (General Routine Care)						133,256	33,761,633		33,761,633	25
26	Intensive Care Unit						15,846	4,114,512		4,114,512	26

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COST ALLOCATION - GENERAL SERVICE COSTS						PROVIDER NO.: 420065		PERIOD: FROM 01/01/2010 TO 12/31/2010		WORKSHEET B PART I	
COST CENTER DESCRIPTIONS		OTHER GENERAL SERVICE	NON-PHYSICIAN ANES-THETISTS	NURSING SCHOOL	INTERNS & RESIDENTS SALARY & FRINGES	INTERNS & RESIDENTS PROGRAM COSTS	PARA-MEDICAL EDUCATION (SPECIFY)	SUBTOTAL	INTERN & RESIDENT COST &POST STEPDOWN ADJUSTMENTS	TOTAL	
		19	20	21	22	23	24	25	26	27	
27	Coronary Care Unit										27
28	Burn Intensive Care Unit										28
29	Surgical Intensive Care Unit										29
30 00	Other Special Care (specify)										30.00
31 00	Subprovider										31.00
33	Nursery							3,503,282		3,503,282	33
34	Skilled Nursery Facility										34
35 00	Nursing Facility										35.00
36	Other Long Term Care										36
	ANCILLARY SERVICE COST CENTERS										
37.05	Operating Room						75,327	21,770,817		21,770,817	37.05
38	Recovery Room							1,496,501		1,496,501	38
39.05	Delivery Room & Labor Room						2,069	3,381,259		3,381,259	39.05
40 00	Anesthesiology										40 00
41.05	Radiology-Diagnostic							10,470,506		10,470,506	41.05
42 00	Radiology-Therapeutic										42.00
43	Radioisotope										43
44.05	Laboratory							5,197,823		5,197,823	44.05
44.10	Oncology							978,770		978,770	44.10
44 45	Vascular Lab							521,493		521,493	44 45
45	PBP Clinical Laboratory Services-Program Only										45
46.00	Whole Blood & Packed Red Blood Cells										46.00
47	Blood Storing, Processing, & Trans.							1,482,877		1,482,877	47
48	Intravenous Therapy										48
49 05	Respiratory Therapy							1,668,133		1,668,133	49 05
50.05	Physical Therapy							3,810,342		3,810,342	50 05
51	Occupational Therapy										51
52	Speech Pathology										52
53 05	Electrocardiology							793,054		793,054	53.05
54	Electroencephalography										54

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COST ALLOCATION - GENERAL SERVICE COSTS						PROVIDER NO.: 420065		PERIOD: FROM 01/01/2010 TO 12/31/2010		WORKSHEET B. PART I	
	COST CENTER DESCRIPTIONS	OTHER GENERAL SERVICE	NON-PHYSICIAN ANES-THETISTS	NURSING SCHOOL	INTERNS & RESIDENTS SALARY & FRINGES	INTERNS & RESIDENTS PROGRAM COSTS	PARA-MEDICAL EDUCATION (SPECIFY)	SUBTOTAL	INTERN & RESIDENT COST &POST STEPDOWN ADJUSTMENTS	TOTAL	
		19	20	21	22	23	24	25	26	27	
55	Medical Supplies Charged to Patients										55
55.30	Implantable Devices Charged to Patients							8,439,508		8,439,508	55.30
56	Drugs Charged to Patients							12,857,336		12,857,336	56
57	Renal Dialysis										57
58	ASAC (Non-Distinct Part)										58
59.30	Other Ancillary Cost Centers							652,063		652,063	59.30
	OUTPATIENT SERVICE COST CENTERS										
60.00	Clinic										60.00
61	Emergency						20,360	9,158,679		9,158,679	61
62.00	Observation Beds										62.00
63.00	Other Outpatient Service (specify)										63.00
	OTHER REIMBURSABLE COST CENTERS										
64	Home Program Dialysis										64
65	Ambulance Services										65
66.00	Durable Medical Equipment-Rented										66.00
67.00	Durable Medical Equipment-Sold										67.00
68	Other Reimbursable (specify)										68
69.00	Outpatient Rehabilitation Provider (specify)										69.00
70	Intern-Resident Service (not apprvd. tchng. prgm.)										70
71	Home Health Agency										71
	SPECIAL PURPOSE COST CENTERS										
82	Lung Acquisition										82
83	Kidney Acquisition										83
84	Liver Acquisition										84
85.00	Heart Acquisition										85.00
86	Other Organ Acquisition (specify)										86
92	Ambulatory Surgical Center (Distinct Part)										92
93	Hospice										93
94	Other Special Purpose (specify)										94
95	SUBTOTALS (sum of lines 1-94)						246,858	124,058,588		124,058,588	95

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COST ALLOCATION - GENERAL SERVICE COSTS						PROVIDER NO.: 420065		PERIOD: FROM 01/01/2010 TO 12/31/2010		WORKSHEET B PART I	
COST CENTER DESCRIPTIONS		OTHER GENERAL SERVICE	NON-PHYSICIAN ANES-THETISTS	NURSING SCHOOL	INTERNS & RESIDENTS SALARY & FRINGES	INTERNS & RESIDENTS PROGRAM COSTS	PARA-MEDICAL EDUCATION (SPECIFY)	SUBTOTAL	INTERN & RESIDENT COST &POST STEPDOWN ADJUSTMENTS	TOTAL	
		19	20	21	22	23	24	25	26	27	
	NONREIMBURSABLE COST CENTERS										
96	Gift, Flower, Coffee Shop, &Canteen							1,106,518		1,106,518	96
97	Research										97
98	Physicians' Private Offices										98
99	Nonpaid Workers										99
100	Other Nonreimbursable (specify)							395,777		395,777	100
101	Cross Foot Adjustments										101
102	Negative Cost Centers										102
103	Total (sum of lines 95-102)						246,858	125,560,883		125,560,883	103

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COST ALLOCATION - STATISTICAL BASIS						PROVIDER NO. 420065		PERIOD: FROM 01/01/2010 TO 12/31/2010		WORKSHEET B-1	
COST CENTER DESCRIPTIONS		Old Capital Related Cost		New Capital Related Cost							
		Bldgs. & Fixtures (SQ FT)	Movable Equipment (Dollar Value)	Bldgs & Fixtures (SQ FT)	Movable Equipment (Dollar Value)	Employee benefits (gross salaries)	Reconcil-iation	Administrative & General (accum cost)	Maintenance & Repairs (Sq Ft)	Operation of Plant (Sq Ft)	
		1	2	3	4	5	6A	6	7	8	
	GENERAL SERVICE COST CENTERS										
1	Old Capital Related Costs-Buildings and Fixtures										1
2	Old Capital Related Costs-Movable Equipment										2
3	New Capital Related Costs-Buildings and Fixtures			344,947							3
4	New Capital Related Costs-Movable Equipment				3,435,677						4
5	Employee Benefits			1,989		48,187,108					5
6.05	Administrative & General			24,393	19,962	4,723,846		102,581,272			6.05
7	Maintenance and Repairs										7
8	Operation of Plant			72,516	234,582	763,880		8,220,185		246,049	8
9	Laundry and Linen Service			2,043				638,494		2,042	9
10	Housekeeping			2,720	9,513	1,235,444		1,944,287		2,719	10
11	Dietary			9,855	18,100	1,161,479		3,031,332		9,854	11
12	Cafeteria										12
13	Maintenance of Personnel										13
14	Nursing Administration			978	17,045	732,858		1,116,472		977	14
15	Central Services and Supply										15
16	Pharmacy										16
17	Medical Records & Medical Records Library			4,485	2,956	167,472		351,815		4,485	17
18	Social Service										18
19.00	Other General Service (specify)										19.00
20	Nonphysician Anesthetists										20
21	Nursing School										21
22	Intern & Res. Service-Salary & Fringes (Approved)										22
23	Intern & Res. Other Program Costs (Approved)										23
24	Paramedical Education Program (specify)			489		128,476		171,935		489	24
	INPATIENT ROUTINE SERVICE COST CENTERS										
25	Adults and Pediatrics (General Routine Care)			102,734	354,328	13,095,687		20,963,226		102,734	25
26	Intensive Care Unit			5,607	29,336	1,902,679		2,840,612		5,606	26

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COST ALLOCATION - STATISTICAL BASIS						PROVIDER NO. 420065		PERIOD. FROM 01/01/2010 TO 12/31/2010		WORKSHEET B-1	
COST CENTER DESCRIPTIONS		Old Capital Related Cost		New Capital Related Cost							
		Bldgs. & Fixtures (SQ FT)	Movable Equipment (Dollar Value)	Bldgs & Fixtures (SQ FT)	Movable Equipment (Dollar Value)	Employee benefits (gross salaries)	Reconcil-iation	Administrative & General (accum cost)	Maintenance & Repairs (Sq. Ft)	Operation of Plant (Sq Ft)	
		1	2	3	4	5	6A	6	7	8	
27	Coronary Care Unit										27
28	Burn Intensive Care Unit										28
29	Surgical Intensive Care Unit										29
30.00	Other Special Care (specify)										30.00
31 00	Subprovider										31.00
33	Nursery			5,165	75,827	1,632,785		2,468,060		5,165	33
34	Skilled Nursing Facility										34
35.00	Nursing Facility										35.00
36	Other Long Term Care										36
	ANCILLARY SERVICE COST CENTERS										
37.05	Operating Room			39,923	1,041,274	5,034,006		15,188,952		39,922	37.05
38	Recovery Room			3,343	55,485	665,912		1,020,586		3,343	38
39 05	Delivery Room & Labor Room			2,489	44,486	1,667,954		2,492,213		2,489	39 05
40 00	Anesthesiology										40.00
41.05	Radiology-Diagnostic			12,905	1,121,477	3,777,914		7,761,691		12,905	41.05
42.00	Radiology-Therapeutic										42.00
43	Radioisotope										43
44.05	Laboratory			5,585	55,850	1,415,680		3,917,276		5,585	44.05
44.10	Oncology			5,206	1,707	290,874		562,791		5,206	44.10
44.45	Vascular Lab			298	69,458	221,939		389,314		298	44.45
45	PBP Clinical Laboratory Services-Program Only										45
46 00	Whole Blood & Packed Red Blood Cells										46 00
47	Blood Storing, Processing, & Trans.			389	950	152,258		1,180,428		388	47
48	Intravenous Therapy										48
49 05	Respiratory Therapy			1,266	23,146	856,828		1,271,224		1,265	49.05
50 05	Physical Therapy			11,879	12,636	1,712,787		2,517,211		11,879	50 05
51	Occupational Therapy										51
52	Speech Pathology										52
53.05	Electrocardiology			1,695	31,827	358,398		557,538		1,694	53.05
54	Electroencephalography										54

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COST ALLOCATION - STATISTICAL BASIS						PROVIDER NO. 420065		PERIOD: FROM 01/01/2010 TO 12/31/2010		WORKSHEET B-1	
COST CENTER DESCRIPTIONS		Old Capital Related Cost		New Capital Related Cost							
		Bldgs. & Fixtures (SQ FT)	Movable Equipment (Dollar Value)	Bldgs. & Fixtures (SQ FT)	Movable Equipment (Dollar Value)	Employee benefits (gross salaries)	Reconcil-iation	Administrative & General (accum cost)	Maintenance & Repairs (Sq. Ft)	Operation of Plant (Sq Ft)	
		1	2	3	4	5	6A	6	7	8	
55	Medical Supplies Charged to Patients										55
55 30	Implantable Devices Charged to Patients							6,844,599			55.30
56	Drugs Charged to Patients			4,520	69,774	2,231,018		10,189,836		4,520	56
57	Renal Dialysis										57
58	ASC (Non-Distinct Part)										58
59 30	Other Ancillary Cost Centers			1,794	525	169,740		446,752		1,793	59.30
	OUTPATIENT SERVICE COST CENTERS										
60.00	Clinic										60.00
61	Emergency			18,216	143,029	3,813,673		6,063,609		18,215	61
62 00	Observation Beds										
63.00	Other Outpatient Service (specify)										63.00
	OTHER REIMBURSABLE COST CENTERS										
64	Home Program Dialysis										64
65	Ambulance Services										65
66.00	Durable Medical Equipment-Rented										66.00
67.00	Durable Medical Equipment-Sold										67.00
68	Other Reimbursable (specify)										68
69.00	Outpatient Rehabilitation Provider (specify)										69.00
70	Intern-Resident Service (not appvd. tchng. prgm.)										70
71	Home Health Agency										71
	SPECIAL PURPOSE COST CENTERS										
82	Lung Acquisition										82
83	Kidney Acquisition										83
84	Liver Acquisition										84
85 00	Heart Acquisition										85.00
86	Other Organ Acquisition (specify)										86
92	Ambulatory Surgical Center (Distinct Part)										92
93	Hospice										93
94	Other Special Purpose (specify)										94
95	SUBTOTALS (sum of lines 1-94)			342,482	3,433,273	47,913,596		102,150,456		243,584	95

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COST ALLOCATION - STATISTICAL BASIS						PROVIDER NO. 420065		PERIOD: FROM 01/01/2010 TO 12/31/2010		WORKSHEET B-1	
COST CENTER DESCRIPTIONS		Old Capital Related Cost		New Capital Related Cost							
		Bldgs. & Fixtures (SQ FT)	Movable Equipment (Dollar Value)	Bldgs. & Fixtures (SQ FT)	Movable Equipment (Dollar Value)	Employee benefits (gross salaries)	Reconcil-iation	Administrative & General (accum cost)	Maintenance & Repairs (Sq. Ft)	Operation of Plant (Sq Ft)	
		1	2	3	4	5	6A	6	7	8	
	NONREIMBURSABLE COST CENTERS										
96	Gift, Flower, Coffee Shop, & Canteen			2,465	2,404	22,108		119,120		2,464	96
97	Research										97
98	Physicians' Private Offices										98
99	Nonpaid Workers										99
100	Other Nonreimbursable (specify)					251,403		311,698			100
101	Cross foot adjustments										101
102	Negative cost centers										102
103	Cost to be allocated (per Wkst. B, Part I)			9,901,723	5,187,655	10,854,387		23,903,179		10,135,628	103
104	Unit cost multiplier (Wkst. B, Part I)			28.705055	1.509937	0.225255		0.233017		41.193535	104
105	Cost to be allocated (per Wkst. B, Part II)										105
106	Unit cost multiplier (Wkst. B, Part II)										106
107	Cost to be allocated (per Wkst. B, Part III)										107
108	Unit cost multiplier (Wkst. B, Part III)										108

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Cost report status - As Submitted
[Record code 267623 - 1996]

COST ALLOCATION - STATISTICAL BASIS						PROVIDER NO.420065		PERIOD: FROM 01/01/2010 TO 12/31/2010		WORKSHEET B-1		
	COST CENTER DESCRIPTIONS	Laundry & Linen Service (LB of Laundry)	Housekeeping (HRs of Service)	Dietary (Meals Served)	Cafeteria (Meals Served)	Maintenance of Personnel (Number Housed)	Nursing Admin ((Direct Nursing Hrs)	Central Services & Supply (Costed Req)	Pharmacy (Costed Req)	Medical Records & Libry (Time Spent)	Social Service (Time Spent)	
		9	10	11	12	13	14	15	16	17	18	
	GENERAL SERVICE COST CENTERS											
1	Old Capital Related Costs-Buildings and Fixtures											1
2	Old Capital Related Costs-Movable Equipment											2
3	New Capital Related Costs-Buildings and Fixtures											3
4	New Capital Related Costs-Movable Equipment											4
5	Employee Benefits											5
6.05	Administrative & General											6.05
7	Maintenance and Repairs											7
8	Operation of Plant											8
9	Laundry and Linen Service	1,009,915										9
10	Housekeeping		241,286									10
11	Dietary		9,854	592,716								11
12	Cafeteria			376,622	69,129							12
13	Maintenance of Personnel											13
14	Nursing Administration		977		967		48,229					14
15	Central Services and Supply											15
16	Pharmacy											16
17	Medical Records & Medical Records Library		4,484		572					165,904,096		17
18	Social Service											18
19.00	Other General Service (specify)											19.00
20	Nonphysician Anesthetists											20
21	Nursing School											21
22	Intern & Res. Service-Salary & Fringes (Approved)											22
23	Intern & Res. Other Program Costs (Approved)											23
24	Paramedical Education Program (specify)		489		375							24
	INPATIENT ROUTINE SERVICE COST CENTERS											
25	Adults and Pediatrics (General Routine Care)	454,003	102,734	88,972	22,745		22,746			44,467,788		25
26	Intensive Care Unit	38,790	5,606	11,150	2,865		2,864			8,225,476		26

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COST ALLOCATION - STATISTICAL BASIS						PROVIDER NO.420065		PERIOD: FROM 01/01/2010 TO 12/31/2010		WORKSHEET B-1		
	COST CENTER DESCRIPTIONS	Laundry & Linen Service (LB of Laundry)	Housekeeping (HRs of Service)	Dietary (Meals Served)	Cafeteria (Meals Served)	Maintenance of Personnel (Number Housed)	Nursing Admin ((Direct Nursing Hrs)	Central Services & Supply (Costed Req)	Pharmacy (Costed Req)	Medical Records & Libry (Time Spent)	Social Service (Time Spent)	
		9	10	11	12	13	14	15	16	17	18	
27	Coronary Care Unit											27
28	Burn Intensive Care Unit											28
29	Surgical Intensive Care Unit											29
30.00	Other Special Care (specify)											30.00
31.00	Subprovider											31.00
33	Nursery	24,827	5,164		2,646		2,646			6,011,713		33
34	Skilled Nursing Facility											34
35.00	Nursing Facility											35.00
36	Other Long Term Care											36
	ANCILLARY SERVICE COST CENTERS											
37.05	Operating Room	172,818	39,922		9,565		9,566			54,860,176		37.05
38	Recovery Room	12,318	3,342		985		985					38
39.05	Delivery Room & Labor Room	46,239	2,489		2,473		2,472					39.05
40.00	Anesthesiology											40.00
41.05	Radiology-Diagnostic	62,222	12,905		6,691					2,175,207		41.05
42.00	Radiology-Therapeutic											42.00
43	Radioisotope											43
44.05	Laboratory		5,584		3,101							44.05
44.10	Oncology	4,633	5,206		477							44.10
44.45	Vascular Lab	20,262	297		335							44.45
45	PBP Clinical Laboratory Services-Program Only											45
46.00	Whole Blood & Packed Red Blood Cells											46.00
47	Blood Storing, Processing, & Trans.		389		284							47
48	Intravenous Therapy											48
49.05	Respiratory Therapy		1,265		1,377							49.05
50.05	Physical Therapy	24,395	11,878		2,829							50.05
51	Occupational Therapy											51
52	Speech Pathology											52
53.05	Electrocardiology		1,694		706							53.05
54	Electroencephalography											54

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COST ALLOCATION - STATISTICAL BASIS						PROVIDER NO.420065		PERIOD: FROM 01/01/2010 TO 12/31/2010		WORKSHEET B-1		
	COST CENTER DESCRIPTIONS	Laundry & Linen Service (LB of Laundry)	Housekeeping (HRs of Service)	Dietary (Meals Served)	Cafeteria (Meals Served)	Maintenance of Personnel (Number Housed)	Nursing Admin ((Direct Nursing Hrs)	Central Services & Supply (Costed Req)	Pharmacy (Costed Req)	Medical Records & Libry (Time Spent)	Social Service (Time Spent)	
		9	10	11	12	13	14	15	16	17	18	
55	Medical Supplies Charged to Patients											55
55.30	Implantable Devices Charged to Patients											55.30
56	Drugs Charged to Patients		4,519		2,333							56
57	Renal Dialysis											57
58	ASC (Non-Distinct Part)											58
59.30	Other Ancillary Cost Centers		1,794		336							59.30
	OUTPATIENT SERVICE COST CENTERS											
60.00	Clinic											60.00
61	Emergency	149,406	18,215		6,946		6,947			50,163,740		61
62.00	Observation Beds											
63.00	Other Outpatient Service (specify)											63.00
	OTHER REIMBURSABLE COST CENTERS											
64	Home Program Dialysis											64
65	Ambulance Services											65
66.00	Durable Medical Equipment-Rented											66.00
67.												67.
68	Other Reimbursable (specify)											68
69.00	Outpatient Rehabilitation Provider (specify)											69.00
70	Intern-Resident Service (not appvd. tchng. prgm.)											70
71	Home Health Agency											71
	SPECIAL PURPOSE COST CENTERS											
82	Lung Acquisition											82
83	Kidney Acquisition											83
84	Liver Acquisition											84
85.00	Heart Acquisition											85.00
86	Other Organ Acquisition (specify)											86
92	Ambulatory Surgical Center (Distinct Part)											92
93	Hospice											93
94	Other Special Purpose (specify)											94
95	SUBTOTALS (sum of lines 1-94)	1,009,915	238,821	476,745	68,617		48,229			165,904,096		95

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COST ALLOCATION - STATISTICAL BASIS						PROVIDER NO.420065		PERIOD: FROM 01/01/2010 TO 12/31/2010		WORKSHEET B-1		
COST CENTER DESCRIPTIONS		Laundry & Linen Service (LB of Laundry)	Housekeeping (HRs of Service)	Dietary (Meals Served)	Cafeteria (Meals Served)	Maintenance of Personnel (Number Housed)	Nursing Admin ((Direct Nursing Hrs)	Central Services & Supply (Costed Req)	Pharmacy (Costed Req)	Medical Records & Libry (Time Spent)	Social Service (Time Spent)	
		9	10	11	12	13	14	15	16	17	18	
	NONREIMBURSABLE COST CENTERS											
96	Gift, Flower, Coffee Shop, & Canteen		2,464	115,970	65							96
97	Research											97
98	Physicians' Private Offices											98
99	Nonpaid Workers											99
100	Other Nonreimbursable (specify)				445							100
101	Cross foot adjustments											101
102	Negative cost centers											102
103	Cost to be allocated (per Wkst. B, Part I)	871,433	2,509,386	4,246,139	1,774,591		1,451,910			679,875		103
104	Unit cost multiplier (Wkst. B, Part I)	0.862877	10.400048	7.163868	25.670717		30.104502			0.004098		104
105	Cost to be allocated (per Wkst. B, Part II)											105
106	Unit cost multiplier (Wkst. B, Part II)											106
107	Cost to be allocated (per Wkst. B, Part III)											107
108	Unit cost multiplier (Wkst. B, Part III)											108

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COST ALLOCATION - STATISTICAL BASIS					PROVIDER NO. 420065		PERIOD: FROM 01/01/2010 . TO 12/31/2010		WORKSHEET B-1		
	COST CENTER DESCRIPTIONS	Other General Service (Specify)	Non-Physician Anesthetists (Assigned Time)	Nursing School (Assigned time)	Salary and Fringes (Assigned Time)	Program Costs (Assigned Time)	Paramedical Educ. Program (Assigned Time)	Subtotal	Intern & Resident Cost and Post Stepdown Adjustment	Total	
		19	20	21	22	23	24	25	26	27	
	GENERAL SERVICE COST CENTERS										
1	Old Capital Related Costs-Buildings and Fixtures										1
2	Old Capital Related Costs-Movable Equipment										2
3	New Capital Related Costs-Buildings and Fixtures										3
4	New Capital Related Costs-Movable Equipment										4
5	Employee Benefits										5
6.05	Administrative & General										6.05
7	Maintenance and Repairs										7
8	Operation of Plant										8
9	Laundry and Linen Service										9
10	Housekeeping										10
11	Dietary										11
12	Cafeteria										12
13	Maintenance of Personnel										13
14	Nursing Administration										14
15	Central Services and Supply										15
16	Pharmacy										16
17	Medical Records & Medical Records Library										17
18	Social Service										18
19.00	Other General Service (specify)										19.00
20	Nonphysician Anesthetists										20
21	Nursing School										21
22	Intern & Res. Service-Salary & Fringes (Approved)										22
23	Intern & Res. Other Program Costs (Approved)										23
24	Paramedical Education Program (specify)						5,250				24
	INPATIENT ROUTINE SERVICE COST CENTERS										
25	Adults and Pediatrics (General Routine Care)						2,833				25
26	Intensive Care Unit						337				26

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COST ALLOCATION - STATISTICAL BASIS					PROVIDER NO. 420065		PERIOD: FROM 01/01/2010 TO 12/31/2010		WORKSHEET B-1		
	COST CENTER DESCRIPTIONS	Other General Service (Specify)	Non-Physician Anesthetists (Assigned Time)	Nursing School (Assigned time)	Salary and Fringes (Assigned Time)	Program Costs (Assigned Time)	Paramedical Educ. Program (Assigned Time)	Subtotal	Intern & Resident Cost and Post Stepdown Adjustment	Total	
		19	20	21	22	23	24	25	26	27	
27	Coronary Care Unit										27
28	Burn Intensive Care Unit										28
29	Surgical Intensive Care Unit										29
30 00	Other Special Care (specify)										30 00
31.00	Subprovider										31.00
33	Nursery										33
34	Skilled Nursing Facility										34
35 00	Nursing Facility										35 00
36	Other Long Term Care										36
	ANCILLARY SERVICE COST CENTERS										
37.05	Operating Room						1,602				37.05
38	Recovery Room										38
39.05	Delivery Room & Labor Room						44				39 05
40 00	Anesthesiology										40.00
41.05	Radiology-Diagnostic										41.05
42.00	Radiology-Therapeutic										42.00
43	Radioisotope										43
44.05	Laboratory										44.05
44.10	Oncology										44.10
44 45	Vascular Lab										44.45
45	PBP Clinical Laboratory Services-Program Only										45
46.00	Whole Blood & Packed Red Blood Cells										46.00
47	Blood Storing, Processing, & Trans.										47
48	Intravenous Therapy										48
49 05	Respiratory Therapy										49.05
50.05	Physical Therapy										50.05
51	Occupational Therapy										51
52	Speech Pathology										52
53.05	Electrocardiology										53.05
54	Electroencephalography										54

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COST ALLOCATION - STATISTICAL BASIS					PROVIDER NO. 420065		PERIOD: FROM 01/01/2010 TO 12/31/2010		WORKSHEET B-1		
	COST CENTER DESCRIPTIONS	Other General Service (Specify)	Non-Physician Anesthetists (Assigned Time)	Nursing School (Assigned time)	Salary and Fringes (Assigned Time)	Program Costs (Assigned Time)	Paramedical Educ. Program (Assigned Time)	Subtotal	Intern & Resident Cost and Post Stepdown Adjustment	Total	
		19	20	21	22	23	24	25	26	27	
55	Medical Supplies Charged to Patients										55
55.30	Implantable Devices Charged to Patients										55.30
56	Drugs Charged to Patients										56
57	Renal Dialysis										57
58	ASC (Non-Distinct Part)										58
59.30	Other Ancillary Cost Centers										59.30
	OUTPATIENT SERVICE COST CENTERS										
60.00	Clinic										60 00
61	Emergency						433				61
62 00	Observation Beds										62 00
63.00	Other Outpatient Service (specify)										63.00
	OTHER REIMBURSABLE COST CENTERS										
64	Home Program Dialysis										64
65	Ambulance Services										65
66.00	Durable Medical Equipment-Rented										66.00
67 00	Durable Medical Equipment-Sold										67.00
68	Other Reimbursable (specify)										68
69.00	Outpatient Rehabilitation Provider (specify)										69.00
70	Intern-Resident Service (not appvd. tchng. prgm.)										70
71	Home Health Agency										71
	SPECIAL PURPOSE COST CENTERS										
82	Lung Acquisition										82
83	Kidney Acquisition										83
84	Liver Acquisition										84
85 00	Heart Acquisition										85 00
86	Other Organ Acquisition (specify)										86
92	Ambulatory Surgical Center (Distinct Part)										92
93	Hospice										93
94	Other Special Purpose (specify)										94
95	SUBTOTALS (sum of lines 1-94)						5,250				95

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COST ALLOCATION - STATISTICAL BASIS					PROVIDER NO. 420065		PERIOD: FROM 01/01/2010 TO 12/31/2010		WORKSHEET B-1		
COST CENTER DESCRIPTIONS		Other General Service (Specify)	Non-Physician Anesthetists (Assigned Time)	Nursing School (Assigned time)	Salary and Fringes (Assigned Time)	Program Costs (Assigned Time)	Paramedical Educ Program (Assigned Time)	Subtotal	Intern & Resident Cost and Post Stepdown Adjustment	Total	
		19	20	21	22	23	24	25	26	27	
	NONREIMBURSABLE COST CENTERS										
96	Gift, Flower, Coffee Shop, & Canteen										96
97	Research										97
98	Physicians' Private Offices										98
99	Nonpaid Workers										99
100	Other Nonreimbursable (specify)										100
101	Cross foot adjustments										101
102	Negative cost centers										102
103	Cost to be allocated (per Wkst B, Part I)						246,858				103
104	Unit cost multiplier (Wkst. B, Part I)						47.020573				104
105	Cost to be allocated (per Wkst. B, Part II)										105
106	Unit cost multiplier (Wkst. B, Part II)										106
107	Cost to be allocated (per Wkst B, Part III)										107
108	Unit cost multiplier (Wkst. B, Part III)										108

*Please note that CostReportData.com worksheets are replicated from electronic cost report data obtained from the CMS Healthcare Cost Report Information System dataset (HCRIS) and may differ from the format submitted by the hospital (e.g. sub-lines and sub-columns may be combined, certain totals have been calculated, etc.).

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COMPUTATION OF RATIO OF COSTS TO CHARGES		PROVIDER NO: 420065				PERIOD: FROM 01/01/2010 TO 12/31/2010			WORKSHEET C, PART I			
	COST CENTER DESCRIPTIONS	Total Cost from Wkst B,Part I col 27	Therapy Limit Adj.	Total Costs	RCE Dis-allowance	Total Costs	Inpatient Charges	Outpatient Charges	Total Charges (col 6 + col 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		1	2	3	4	5	6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS												
25	Adults and Pediatrics (General Routine Care)	33,761,633		33,761,633		33,761,633	44,467,768		44,467,768				25
26	Intensive Care Unit	4,114,512		4,114,512		4,114,512	8,225,419		8,225,419				26
27	Coronary Care Unit												27
28	Burn Intensive Care Unit												28
29	Surgical Intensive Care Unit												29
30 00	Other Special Care (specify)												30.00
31 00	Subprovider												31.00
33	Nursery	3,503,282		3,503,282		3,503,282	6,011,620		6,011,620				33
34	Skilled Nursing Facility												34
35 00	Nursing Facility												35.00
36	Other Long Term Care												36
	ANCILLARY SERVICE COST CENTERS												
37.05	Operating Room	21,770,817		21,770,817		21,770,817	34,623,836	54,846,154	89,469,990	0.243331	0.243331	0.243331	37.05
38	Recovery Room	1,496,501		1,496,501		1,496,501	3,383,325	5,196,605	8,579,930	0.174419	0.174419	0.174419	38
39.05	Delivery Room & Labor Room	3,381,259		3,381,259		3,381,259	10,413,531	766,978	11,180,509	0.302424	0.302424	0.302424	39.05
40.00	Anesthesiology												40.00
41.05	Radiology-Diagnostic	10,470,506		10,470,506		10,470,506	13,126,877	84,245,581	97,372,458	0.107530	0.107530	0.107530	41.05
42 00	Radiology-Therapeutic												42.00
43	Radioisotope												43
44.05	Laboratory	5,197,823		5,197,823		5,197,823	31,677,723	30,909,930	62,587,653	0.083049	0.083049	0.083049	44.05
44.10	Oncology	978,770		978,770		978,770		2,371,726	2,371,726	0.412683	0.412683	0.412683	44.10
44 45	Vascular Lab	521,493		521,493		521,493	1,216,268	3,285,239	4,501,507	0 115849	0.115849	0.115849	44.45
45	PBP Clinical Laboratory Services-Pgm Only												45
46.00	Whole Blood & Packed Red Blood Cells												46.00
47	Blood Storing, Processing, & Trans.	1,482,877		1,482,877		1,482,877	4,681,787	1,462,434	6,144,221	0.241345	0.241345	0.241345	47
48	Intravenous Therapy												48
49 05	Respiratory Therapy	1,668,133		1,668,133		1,668,133	4,525,435	303,918	4,829,353	0.345415	0.345415	0.345415	49.05
50.05	Physical Therapy	3,810,342		3,810,342		3,810,342	1,984,877	7,606,664	9,591,541	0.397261	0.397261	0.397261	50.05

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COMPUTATION OF RATIO OF COSTS TO CHARGES						PROVIDER NO: 420065			PERIOD FROM 01/01/2010 TO 12/31/2010			WORKSHEET C, PART I	
	COST CENTER DESCRIPTIONS	Total Cost from Wkst B,Part I col 27	Therapy Limit Adj.	Total Costs	RCE Dis-allowance	Total Costs	Inpatient Charges	Outpatient Charges	Total Charges (col 6 + col 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		1	2	3	4	5	6	7	8	9	10	11	
51	Occupational Therapy												51
52	Speech Pathology												52
53.05	Electrocardiology	793,054		793,054		793,054	2,723,203	3,466,422	6,189,625	0.128126	0.128126	0.128126	53.05
54	Electroencephalography												54
55	Medical Supplies Charged to Patients												55
55.30	Implantable Devices Charged to Patients	8,439,508		8,439,508		8,439,508	16,593,519	3,334,125	19,927,644	0.423508	0.423508	0.423508	55.30
56	Drugs Charged to Patients	12,857,336		12,857,336		12,857,336	27,011,931	24,444,932	51,456,863	0.249866	0.249866	0.249866	56
57	Renal Dialysis												57
58	ASC (Non-Distinct Part)												58
59.30	Other Ancillary Cost Centers	652,063		652,063		652,063	400,657	232,706	633,363	1.029525	1.029525	1.029525	59.30
OUTPATIENT SERVICE COST CENTERS													
60.00	Clinic												60.00
61	Emergency	9,158,679		9,158,679		9,158,679	10,329,255	50,163,776	60,493,031	0.151401	0.151401	0.151401	61
62.10	Observation Beds (Non-DistinctPart)	1,347,645		1,347,645		1,347,645		1,529,979	1,529,979	0.880826	0.880826	0.880826	62.10
63.00	Other Outpatient Service (specify)												63.00
OTHER REIMBURSABLE COST CENTERS													
64	Home Program Dialysis												64
65	Ambulance Services												65
66.00	Durable Medical Equipment-Rented												66.00
67.00	Durable Medical Equipment-Sold												67.00
68	Other Reimbursable (specify)												68
101	Subtotal (sum of lines 25 thru 68)	125,406,233		125,406,233		125,406,233	221,397,031	274,167,169	495,564,200				101
102	Less Observation Beds	1,347,645		1,347,645		1,347,645							102
103	Total (line 101 minus line 102)	124,058,588		124,058,588		124,058,588	221,397,031	274,167,169	495,564,200				103

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CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS						PROVIDER NO. 420065		PERIOD: FROM 01/01/2010 TO 12/31/2010		WORKSHEET C, PART II	
	Cost Center Descriptions	Total Cost (Wkst. B, Part I, col. 27)	Capital Cost (Wkst. B, sum of Parts II & III, col. 27)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	Cost Net of Capital and Operating Cost Reduction	Total Charges (Wkst. C, Part I, col. 8)	Outpatient Cost to Charge Ratio (col. 6 ÷ col. 7)	I/P Part B Cost to Charge Ratio (see instruc.)	
		1	2	3	4	5	6	7	8	9	
	ANCILLARY SERVICE COST CENTERS										
37.05	Operating Room	21,770,817	21,770,817					89,469,990		0.243331	37.05
38	Recovery Room	1,496,501	1,496,501					8,579,930		0.174419	38
39.05	Delivery Room & Labor Room	3,381,259	3,381,259					11,180,509		0.302424	39.05
40.00	Anesthesiology										40.00
41.05	Radiology-Diagnostic	10,470,506	10,470,506					97,372,458		0.107530	41.05
42.00	Radiology-Therapeutic										42.00
43	Radioisotope										43
44.05	Laboratory	5,197,823	5,197,823					62,587,653		0.083049	44.05
44.10	Oncology	978,770	978,770					2,371,726		0.412683	44.10
44.45	Vascular Lab	521,493	521,493					4,501,507		0.115849	44.45
45	PBP Clinical Laboratory Services-Prgm. Only										45
46.00	Whole Blood & Packed Red Blood Cells										46.00
47	Blood Storing, Processing, & Trans.	1,482,877	1,482,877					6,144,221		0.241345	47
48	Intravenous Therapy										48
49.05	Respiratory Therapy	1,668,133	1,668,133					4,829,353		0.345415	49.05
50.05	Physical Therapy	3,810,342	3,810,342					9,591,541		0.397261	50.05
51	Occupational Therapy										51
52	Speech Pathology										52
53.05	Electrocardiology	793,054	793,054					6,189,625		0.128126	53.05
54	Electroencephalography										54
55	Medical Supplies Charged to Patients										55
56	Drugs Charged to Patients	12,857,336	12,857,336					51,456,863		0.249866	56
57	Renal Dialysis										57
58	ASC (Non-Distinct Part)										58
59.30	Other Ancillary Cost Centers	652,063	652,063					633,363		1.029525	59.30
60.00	Clinic										60.00
61	Emergency	9,158,679	9,158,679					60,493,031		0.151401	61
62.10	Observation Beds (Non-DistinctPart)							1,529,979			62.10

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CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS						PROVIDER NO. 420065		PERIOD: FROM 01/01/2010 TO 12/31/2010		WORKSHEET C, PART II	
	Cost Center Descriptions	Total Cost (Wkst. B, Part 1, col. 27)	Capital Cost (Wkst. B, sum of Parts II & III, col 27)	Operating Cost Net of Capital Cost (col 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	Cost Net of Capital and Operating Cost Reduction	Total Charges (Wkst. C, Part I, col 8)	Outpatient Cost to Charge Ratio (col. 6 ÷ col. 7)	I/P Part B Cost to Charge Ratio (see instruc.)	
		1	2	3	4	5	6	7	8	9	
63.00	Other Outpatient Service (specify)										63.00
	OTHER REIMBURSABLE COST CENTERS										
64	Home Program Dialysis										64
65	Ambulance Services										65
66	Durable Medical Equipment - Rented										66
67	Durable Medical Equipment - Sold										67
68	Other Reimbursable (specify)										68
101	Subtotal (sum of lines 37-68)							495,564,200			101
102	Less Observation Beds										102
103	Total (sum of line 101 minus line 102)	125,560,883						495,564,200			103

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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS	PROVIDER NO. 420065	PERIOD: FROM 01/01/2010 TO: 12/31/2010	WORKSHEET D, PART I

Medicare -Title XVIII - Hospital - 420065

	Cost Center Description	Old Capital			New Capital					Old Capital		New Capital		
		Capital Related Cost (from Wkst. B, Part II, col 27)	Swing Bed Adj.	Reduced Capital Related Cost (col. 1 - col. 2)	Capital Related Cost (from Wkst. B, Part III, col 27)	Swing Bed Adj.	Reduced Capital Related Cost (col. 4 - col. 5)	Total Patient Days	Inpatient Program Days	Per Diem (col. 3 ÷ col. 7)	Inpatient Program Capital Cost (col. 9 x col. 8)	Per Diem (col. 6 ÷ col. 7)	Inpatient Program Capital Cost (col. 11 x col. 8)	
		1	2	3	4	5	6	7	8	9	10	11	12	
(A)	INPATIENT ROUTINE SERVICE COST CENTERS													
25	Adults & Pediatrics (General Routine Care)				4,999,001		4,999,001	31,115	12,118			160.66	1,946,878	25
26	Intensive Care Unit				320,672		320,672	2,462	1,213			130.25	157,993	26
27	Coronary Care Unit													27
28	Burn Intensive Care Unit													28
29	Surgical Intensive Care Unit													29
30.00	Other Special Care (specify)													30.00
31.00	Subprovider													31.00
33	Nursery				357,643		357,643	4,629				77.26		33
101	Total (lines 25-33)				5,677,316		5,677,316	38,206	13,331				2,104,871	101

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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	PROVIDER NO: 420065	PERIOD: FROM: 01/01/2010 TO: 12/31/2010	WORKSHEET D, PART II

Medicare -Title XVIII - Hospital - 420065

	Cost Center Description	Old Capital Related Cost (from Wkst. B, Part II, col. 27)	New Capital Related Cost (from Wkst. B, Part III, col. 27)	Total Charges (from Wkst. C, Part 1, col. 8)	Inpatient Program Charges	Old Capital: Ratio of Cost to Charges (col. 1 ÷ col. 3)	Old Capital: Capital Costs (col. 4 x col. 5)	New Capital: Ratio of Cost to Charges (col. 2 ÷ col. 3)	New Capital: Capital Costs (col. 4 x col. 7)	
		1	2	3	4	5	6	7	8	
(A)	ANCILLARY SERVICE COST CENTERS									
37.05	Operating Room		3,376,597	89,469,990	11,404,503			0.037740	430,406	37.05
38	Recovery Room		228,824	8,579,930	1,086,375			0.026670	28,974	38
39.05	Delivery Room & Labor Room		199,405	11,180,509	11,174			0.017835	199	39.05
40.00	Anesthesiology									40.00
41.05	Radiology-Diagnostic		2,287,453	97,372,458	6,728,201			0.023492	158,059	41.05
42.00	Radiology-Therapeutic									42.00
43	Radioisotope									43
44.05	Laboratory		342,439	62,587,653	15,951,997			0.005471	87,273	44.05
44.10	Oncology		213,774	2,371,726				0.090134		44.10
44.45	Vascular Lab		122,250	4,501,507	723,635			0.027158	19,652	44.45
45	PBP Clinical Laboratory Services-Prgm. Only									45
46.00	Whole Blood & Packed Red Blood Cells									46.00
47	Blood Storing, Processing, & Transfusing		26,168	6,144,221	2,208,570			0.004259	9,406	47
48	Intravenous Therapy									48
49.05	Respiratory Therapy		98,633	4,829,353	2,745,203			0.020424	56,068	49.05
50.05	Physical Therapy		516,847	9,591,541	1,227,024			0.053886	66,119	50.05
51	Occupational Therapy									51
52	Speech Pathology									52
53.05	Electrocardiology		121,156	6,189,625	1,601,205			0.019574	31,342	53.05
54	Electroencephalography									54
55	Medical Supplies Charged to Patients									55
55.30	Implantable Devices Charged to Patients		49,103	19,927,644	5,593,474			0.002464	13,782	55.30
56	Drugs Charged to Patients		365,419	51,456,863	12,574,066			0.007101	89,288	56
57	Renal Dialysis									57
58	ASC (Non-Distinct Part)									58
59.30	Other Ancillary Cost Centers		75,793	633,363	261,085			0.119668	856	59.30

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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	PROVIDER NO: 420065	PERIOD: FROM: 01/01/2010 TO: 12/31/2010	WORKSHEET D, PART II

Medicare -Title XVIII - Hospital - 420065

	Cost Center Description	Old Capital Related Cost (from Wkst. B, Part II, col. 27)	New Capital Related Cost (from Wkst. B, Part III, col. 27)	Total Charges (from Wkst. C, Part I, col. 8)	Inpatient Program Charges	Old Capital: Ratio of Cost to Charges (col 1 ÷ col. 3)	Old Capital: Capital Costs (col. 4 x col. 5)	New Capital: Ratio of Cost to Charges (col. 2 ÷ col. 3)	New Capital: Capital Costs (col. 4 x col. 7)	
		1	2	3	4	5	6	7	8	
60.00	Clinic									60.00
61	Emergency		1,079,703	60,493,031	5,176,321			0.017848	92,387	61
62.10	Observation Beds (Non-DistinctPart)			1,529,979						62.10
63.00	Other Outpatient Service (specify)									63.00
	OTHER REIMBURSABLE COST CENTERS									
64	Home Program Dialysis									64
65	Ambulance Services									65
66.00	Durable Medical Equipment-Rented									66.00
67.00	Durable Medical Equipment-Sold									67.00
68	Other Reimbursable (specify)									68
101	Total (sum of lines 37 through 68)		9,103,564	436,859,393	67,292,833				1,083,811	101

(A) Worksheet A line numbers

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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	PROVIDER NO: 420065	PERIOD: FROM: 01/01/2010 TO: 12/31/2010	WORKSHEET D, PART III

Medicare -Title XVIII - Hospital - 420065

	Cost Center Description	Nonphysician Anesthetist Cost	Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Tota Costs (sum of cols. 1 + 2, minus col. 3)	Total Patient Days	Per Diem (col. 4 + col. 5)	Inpatient Program Days	Inpatient Program Pass thru Cost (col. 6 x col. 7)	
		1	2	3	4	5	6	7	8	
(A)	INPATIENT ROUTINE SERVICE COST CENTERS									
25	Adults & Pediatrics (General Routine Care)		133,256		133,256	31,115	4.28	12,118	51,865	25
26	Intensive Care Unit		15,846		15,846	2,462	6.44	1,213	7,812	26
27	Coronary Care Unit									27
28	Burn Intensive Care Unit									28
29	Surgical Intensive Care Unit									29
30.00	Other Special Care (specify)									30.00
31 00	Subprovider									31 00
33	Nursery					4,629				33
34	Skilled Nursing Facility									34
35 00	Nursing Facility									35 00
101	Total (sum of lines 25-35)		149,102		149,102	38,206		13,331	59,677	101

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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	PROVIDER NO: 420065	PERIOD: FROM: 01/01/2010 TO: 12/31/2010	WORKSHEET D, PART III

Medicaid - Title XIX - Hospital - 420065

	Cost Center Description	Nonphysician Anesthetist Cost	Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Tota Costs (sum of cols. 1 + 2, minus col. 3)	Total Patient Days	Per Diem (col. 4 ÷ col. 5)	Inpatient Program Days	Inpatient Program Pass thru Cost (col. 6 x col. 7)	
		1	2	3	4	5	6	7	8	
(A)	INPATIENT ROUTINE SERVICE COST CENTERS									
25	Adults & Pediatrics (General Routine Care)									25
26	Intensive Care Unit									26
27	Coronary Care Unit									27
28	Burn Intensive Care Unit									28
29	Surgical Intensive Care Unit									29
30.00	Other Special Care (specify)									30.00
31 00	Subprovider									31 00
33	Nursery									33
34	Skilled Nursing Facility									34
35 00	Nursing Facility									35 00
101	Total (sum of lines 25-35)								10,254	101

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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	PROVIDER NO 420065	PERIOD: FROM: 01/01/2010 TO: 12/31/2010	WORKSHEET D, PART IV

Medicare - Title XVIII - Hospital - 420065

	Cost Center Description	Nonphysician Anesthetist Cost	Medical Education Cost	Total Costs (col. 1 + col. 2)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 3 ÷ col. 4)	Inpatient Program Charges	Inpatient Program Pass Through Costs (col. 5 × col. 6)	Outpatient Program Charges	Outpatient Program Pass Through Costs (col. 5 × col. 8)	
		1	2	3	4	5	6	7	8	9	
(A)	ANCILLARY SERVICE COST CENTERS										
37.05	Operating Room		75,327	75,327	89,469,990	0.000842	11,404,503	9,603	14,971,695	12,606	37.05
38	Recovery Room				8,579,930		1,086,375		1,083,415		38
39.05	Delivery Room & Labor Room		2,069	2,069	11,180,509	0.000185	11,174	2			39.05
40.00	Anesthesiology										40.00
41.05	Radiology-Diagnostic				97,372,458		6,728,201		26,204,948		41.05
42.00	Radiology-Therapeutic										42.00
43	Radioisotope										43
44.05	Laboratory				62,587,653		15,951,997		8,785,691		44.05
44.10	Oncology				2,371,726				1,031,688		44.10
44.45	Vascular Lab				4,501,507		723,635		1,566,385		44.45
45	PBP Clinical Laboratory Services-Prgm Only										45
46.00	Whole Blood & Packed Red Blood Cells										46.00
47	Blood Storing, Processing, & Transfusing				6,144,221		2,208,570		590,135		47
48	Intravenous Therapy										48
49.05	Respiratory Therapy				4,829,353		2,745,203		115,029		49.05
50.05	Physical Therapy				9,591,541		1,227,024		2,614,071		50.05
51	Occupational Therapy										51
52	Speech Pathology										52
53.05	Electrocardiology				6,189,625		1,601,205		1,377,071		53.05
54	Electroencephalography										54
55	Medical Supplies Charged to Patients										55
55.30	Implantable Devices Charged to Patients						5,593,474		1,311,729		55.30
56	Drugs Charged to Patients				51,456,863		12,574,066		8,790,897		56
57	Renal Dialysis										57
58	ASC (Non-Distinct Part)										58
59.30	Other Ancillary Cost Centers				633,363		261,085		62,526		59.30
	OUTPATIENT SERVICE COST CENTERS										
60.00	Clinic										60.00
61	Emergency		20,360	20,360	60,493,031	0 000337	5,176,321	1,744	9,627,644	3,245	61
62.10	Observation Beds (Non-DistinctPart)		5,319	5,319	1,529,979	0 003477			438,528	1,525	62.10
63.00	Other Outpatient Service (specify)										63.00
	OTHER REIMBURSABLE COST CENTERS										

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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS		PROVIDER NO: 420065	PERIOD: FROM: 01/01/2010 TO: 12/31/2010	WORKSHEET D, PART IV

Medicare - Title XVIII - Hospital - 420065

	Cost Center Description	Nonphysician Anesthetist Cost	Medical Education Cost	Total Costs (col. 1 + col. 2)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 3 ÷ col. 4)	Inpatient Program Charges	Inpatient Program Pass Through Costs (col. 5 × col. 6)	Outpatient Program Charges	Outpatient Program Pass Through Costs (col. 5 × col. 8)	
		1	2	3	4	5	6	7	8	9	
64	Home Program Dialysis										64
65	Ambulance Services										65
66.00	Durable Medical Equipment-Rented										66.00
67.00	Durable Medical Equipment-Sold										67.00
68	Other Reimbursable (specify)										68
101	Total (sum of lines 37 through 68)		103,075	103,075	416,931,749		67,292,833	11,349	78,571,453	17,376	101

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APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	PROVIDER NO: 420065	PERIOD: FROM 01/01/2010 TO 12/31/2010	WORKSHEET D, PARTS V & VI

Medicare -Title XVIII - Hospital - 420065

PART V - APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

	Cost Center Description	Cost to Charge Ratio From Worksheet C			PROGRAM CHARGES						PROGRAM COSTS								
		Part II col 8	Part I col. 9	Part II col. 9	Outpatient Ambulatory Surgical Center	Outpatient Radiology	Other Outpatient Diagnostic	All Other (1) (see instru.)	PPS services (see instru.)	All Other (see instru.)	Outpatient Ambulatory Surgical Center (cols. 1 × 2)	Outpatient Radiology (cols. 1 × 3)	Other Outpatient Diagnostic (cols 1 × 4)	All Other (cols. 1 × 5)	PPS services (columns 1.01 × 5.01)	All Other (columns 1.01 × 5.02)	Hospital I/P Part B Charges (see instru.)	Hospital I/P part B Cost (columns 1.02 × 10)	
		1	1.01	1.02	2	3	4	5	5.01	5.02	6	7	8	9	9.01	9.02	10	11	
	ANCILLARY SERVICE COST CENTERS																		
37.05	Operating Room		0.243331	0.243331					14,971,695						3,643,078				37.05
38	Recovery Room		0.174419	0.174419					1,083,415						188,968				38
39.05	Delivery Room & Labor Room		0.302424	0.302424															39.05
40.00	Anesthesiology																		40.00
41.05	Radiology-Diagnostic		0.107530	0.107530					26,204,948						2,817,818				41.05
42.00	Radiology-Therapeutic																		42.00
43	Radioisotope																		43
44.05	Laboratory		0.083049	0.083049					8,785,691						729,643				44.05
44.10	Oncology		0.412683	0.412683					1,031,688						425,760				44.10
44.45	Vascular Lab		0.115849	0.115849					1,566,385						181,464				44.45
45	PBP Clinic Laboratory Services-Prgm. Only																		45
46.00	Whole Blood & Packed Red Blood Cells																		46.00
47	Blood Storing, Processing, & Transfusing		0.241345	0.241345					590,136						142,426				47
48	Intravenous Therapy																		48
49.05	Respiratory Therapy		0.345415	0.345415					115,029						39,733				49.05
50.05	Physical Therapy		0.397261	0.397261					2,614,071						1,038,468				50.05
51	Occupational Therapy																		51
52	Speech Pathology																		52
53.05	Electrocardiology		0.128126	0.128126					1,377,071						176,439				53.05
54	Electroencephalography																		54
55	Medical Supplies Charged To Patients																		55
55.30	Implantable Devices Charged to Patients								1,311,729						555,528				55.30
56	Drugs Charged To Patients		0.249866	0.249866					8,790,897						2,196,546				56
57	Renal Dialysis																		57
58	ASC (Non-Distinct Part)																		58
59.30	Other Ancillary Cost Centers		1.029525	1.029525					62,526						114,567				59.30

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APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	PROVIDER NO: 420065	PERIOD: FROM 01/01/2010 TO 12/31/2010	WORKSHEET D, PARTS V & VI

Medicare -Title XVIII - Hospital - 420065

PART V - APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

	Cost Center Description	Cost to Charge Ratio From Worksheet C			PROGRAM CHARGES						PROGRAM COSTS								
		Part II col. 8	Part I col. 9	Part II col. 9	Outpatient Ambulatory Surgical Center	Outpatient Radiology	Other Outpatient Diagnostic	All Other (1) (see instru.)	PPS services (see instru.)	All Other (see instru.)	Outpatient Ambulatory Surgical Center (cols. 1 × 2)	Outpatient Radiology (cols. 1 × 3)	Other Outpatient Diagnostic (cols 1 × 4)	All Other (cols. 1 × 5)	PPS services (columns 1.01 × 5.01)	All Other (columns 1.01 × 5.02)	Hospital I/P Part B Charges (see instru.)	Hospital I/P part B Cost (columns 1.02 × 10)	
		1	1.01	1.02	2	3	4	5	5.01	5.02	6	7	8	9	9.01	9.02	10	11	
	OUTPATIENT SERVICE COST CENTERS																		
60.00	Clinic																		60.00
61	Emergency		0.151401	0.151401					9,627,644						1,457,635				61
62.10	Observation Beds (Non-DistinctPart)		0.880826						438,528						386,267				62.10
63.00	Other Outpatient Service (specify)																		63.00
	OTHER REIMBURSABLE COST CENTERS																		
64	Home Program Dialysis																		64
65	Ambulance																		65
66.00	Durable Medical Equipment-Rented																		66.00
67.00	Durable Medical Equipment-Sold																		67.00
68	Other Reimbursable Cost Center																		68
101	Subtotal (see instructions)								78,571,453						14,094,340				101
102	CRNA Charges (see instructions)																		102
103	Less PBP Clinic Lab. Services-Program Only Charges																		103
104	Net Charges (line 101 ± (lines 102 + 103)								78,571,453						14,094,340				104

PART VI - VACCINE COST APPORTIONMENT

		1	
1	Drugs charged to patients - ratio of cost to charges (from Worksheet C, Part I, column 9, line 56)		1
2	Program vaccine charges (from your records or the PS&R)		2
3	Program costs (line 1 × lines 2) (see instructions for transfer)		3
	(A) Worksheet A line numbers (1) Report non hospital and non subprovider componenents cost for the period here (see instructions)		

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ST. FRANCIS XAVIER BON SECOURS - CHARLESTON, SC
Cost report status - As Submitted
[Record code 267623 - 1996]

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	PROVIDER NO: 420065	PERIOD: FROM 01/01/2010 TO 12/31/2010	WORKSHEET D, PARTS V & VI

Medicaid - Title XIX - Hospital - 420065

PART V - APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

	Cost Center Description	Cost to Charge Ratio From Worksheet C			PROGRAM CHARGES						PROGRAM COSTS								
		Part II col. 8	Part I col. 9	Part II col. 9	Outpatient Ambulatory Surgical Center	Outpatient Radiology	Other Outpatient Diagnostic	All Other (1) (see instru.)	PPS services (see instru.)	All Other (see instru.)	Outpatient Ambulatory Surgical Center (cols. 1 × 2)	Outpatient Radiology (cols. 1 × 3)	Other Outpatient Diagnostic (cols. 1 × 4)	All Other (cols. 1 × 5)	PPS services (columns 1.01 × 5.01)	All Other (columns 1.01 × 5.02)	Hospital I/P Part B Charges (see instru.)	Hospital I/P part B Cost (columns 1.02 × 10)	
		1	1.01	1.02	2	3	4	5	5.01	5.02	6	7	8	9	9.01	9.02	10	11	
	ANCILLARY SERVICE COST CENTERS																		
37.05	Operating Room		0.243331	0.243331				1,182,278						269,125					37.05
38	Recovery Room		0.174419	0.174419				146,251						23,866					38
39.05	Delivery Room & Labor Room		0.302424	0.302424				140,360						39,881					39.05
40.00	Anesthesiology																		40.00
41.05	Radiology-Diagnostic		0.107530	0.107530				1,979,813						198,589					41.05
42.00	Radiology-Therapeutic																		42.00
43	Radioisotope																		43
44.05	Laboratory		0.083049	0.083049				1,246,290						97,213					44.05
44.10	Oncology		0.412683	0.412683				82,364						31,707					44.10
44.45	Vascular Lab		0.115849	0.115849				45,611						4,925					44.45
45	PBP Clinic Laboratory Services-Prgm. Only																		45
46.00	Whole Blood & Packed Red Blood Cells																		46.00
47	Blood Storing, Processing, & Transfusing		0.241345	0.241345				54,618						12,407					47
48	Intravenous Therapy																		48
49.05	Respiratory Therapy		0.345415	0.345415				10,817						3,510					49.05
50.05	Physical Therapy		0.397261	0.397261				121,309						45,122					50.05
51	Occupational Therapy																		51
52	Speech Pathology																		52
53.05	Electrocardiology		0.128126	0.128126				49,299						5,910					53.05
54	Electroencephalography																		54
55	Medical Supplies Charged To Patients																		55
55.30	Implantable Devices Charged to Patients							24,881						9,924					55.30
56	Drugs Charged To Patients		0.249866	0.249866				762,404						179,223					56
57	Renal Dialysis																		57
58	ASC (Non-Distinct Part)																		58
59.30	Other Ancillary Cost Centers		1.029525	1.029525				8,808						15,085					59.30

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APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	PROVIDER NO: 420065	PERIOD: FROM 01/01/2010 TO 12/31/2010	WORKSHEET D, PARTS V & VI

Medicaid - Title XIX - Hospital - 420065

PART V - APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

	Cost Center Description	Cost to Charge Ratio From Worksheet C			PROGRAM CHARGES						PROGRAM COSTS								
		Part II col. 8	Part I col. 9	Part II col. 9	Outpatient Ambulatory Surgical Center	Outpatient Radiology	Other Outpatient Diagnostic	All Other (1) (see instru.)	PPS services (see instru.)	All Other (see instru.)	Outpatient Ambulatory Surgical Center (cols. 1 × 2)	Outpatient Radiology (cols. 1 × 3)	Other Outpatient Diagnostic (cols. 1 × 4)	All Other (cols. 1 × 5)	PPS services (columns 1.01 × 5.01)	All Other (columns 1.01 × 5.02)	Hospital I/P Part B Charges (see instru.)	Hospital I/P part B Cost (columns 1.02 × 10)	
		1	1.01	1.02	2	3	4	5	5.01	5.02	6	7	8	9	9.01	9.02	10	11	
	OUTPATIENT SERVICE COST CENTERS																		
60.00	Clinic																		60.00
61	Emergency		0.151401	0.151401				2,606,544						369,790					61
62.10	Observation Beds (Non-DistinctPart)		0.880826					22,941						18,909					62.10
63.00	Other Outpatient Service (specify)																		63.00
	OTHER REIMBURSABLE COST CENTERS																		
64	Home Program Dialysis																		64
65	Ambulance																		65
66.00	Durable Medical Equipment-Rented																		66.00
67.00	Durable Medical Equipment-Sold																		67.00
68	Other Reimbursable Cost Center																		68
101	Subtotal (see instructions)							8,484,588						1,325,186					101
102	CRNA Charges (see instructions)																		102
103	Less PBP Clinic Lab. Services-Program Only Charges																		103
104	Net Charges (line 101 ± (lines 102 + 103)							8,484,588						1,325,186					104

PART VI - VACCINE COST APPORTIONMENT

		1	
1	Drugs charged to patients - ratio of cost to charges (from Worksheet C, Part I, column 9, line 56)		1
2	Program vaccine charges (from your records or the PS&R)		2
3	Program costs (line 1 × lines 2) (see instructions for transfer)		3
	(A) Worksheet A line numbers (1) Report non hospital and non subprovider componenents cost for the period here (see instructions)		

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	COMPUTATION OF INPATIENT OPERATING COST	PROVIDER NO: 420065	PERIOD: FROM 01/01/2010 TO 12/31/2010	WORKSHEET D-1, PART I	
Medicare -Title XVIII - Hospital - 420065					
PART I - ALL PROVIDER COMPONENTS					
	INPATIENT DAYS				
1	Inpatient days (including private room days, and swing-bed days, excluding new born)			31,115	1
2	Inpatient days (including private room days, excluding swing-bed days and new born days)			31,115	2
3	Private room days (excluding swing-bed private room days)				3
4	Semi-private room days (excluding swing-bed private room days)			31,115	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period				5
6	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)				6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period				7
8	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)				8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and new born days)			12,118	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period				10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after Decmeber 31 of the cost reporting period				11
12	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				12
13	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)				13
14	Medically necessary private room days applicable to the Program (excluding swing-bed days)				14
15	Total nursery days				15
16	Title V or XIX nursery days				16
	SWING BED ADJUSTEMENT				
17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period				17
18	Medicare rate for swing-bed SNF services applicable to services after Decmeber 31 of the cost reporting period				18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period				19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period				20
21	Total general inpatient routine service cost (see instructions)			33,761,633	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 × line 17)				22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 × line 18)				23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 × line 18)				24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 × line 20)				25
26	Total swing-bed cost (sum of lines 22 through 25)				26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			33,761,633	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28	General inpatient routine service charges (excluding swing-bed charges)				28
29	Private room charges (excluding swing-bed charges)				29
30	Semi-private room charges (excluding swing-bed charges)				30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)				31
32	Average private room per diem charge (line 29 ÷ line 3)				32
33	Average semi-private room per diem charge (line 30 ÷ line 4)				33
34	Average per diem private room charge differential (line 32 minus line 33)				34
35	Average per diem private private room cost differential (line 34 × line 31)				35
36	Private room cost differential adjustment (line 3 × line 35)				36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			33,761,633	37

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	COMPUTATION OF INPATIENT OPERATING COST	PROVIDER NO: 420065	PERIOD: FROM 01/01/2010 TO 12/31/2010	WORKSHEET D-1, PART I	
Medicaid - Title XIX - Hospital - 420065					
PART I - ALL PROVIDER COMPONENTS					
	INPATIENT DAYS				
1	Inpatient days (including private room days, and swing-bed days, excluding new born)			31,115	1
2	Inpatient days (including private room days, excluding swing-bed days and new born days)			31,115	2
3	Private room days (excluding swing-bed private room days)				3
4	Semi-private room days (excluding swing-bed private room days)			31,115	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period				5
6	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)				6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period				7
8	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)				8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and new born days)			2,104	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period				10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after Decmeber 31 of the cost reporting period				11
12	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				12
13	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)				13
14	Medically necessary private room days applicable to the Program (excluding swing-bed days)				14
15	Total nursery days			4,629	15
16	Title V or XIX nursery days			457	16
	SWING BED ADJUSTEMENT				
17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period				17
18	Medicare rate for swing-bed SNF services applicable to services after Decmeber 31 of the cost reporting period				18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period				19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period				20
21	Total general inpatient routine service cost (see instructions)			33,761,633	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 × line 17)				22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 × line 18)				23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 × line 18)				24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 × line 20)				25
26	Total swing-bed cost (sum of lines 22 through 25)				26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			33,761,633	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28	General inpatient routine service charges (excluding swing-bed charges)				28
29	Private room charges (excluding swing-bed charges)				29
30	Semi-private room charges (excluding swing-bed charges)				30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)				31
32	Average private room per diem charge (line 29 ÷ line 3)				32
33	Average semi-private room per diem charge (line 30 ÷ line 4)				33
34	Average per diem private room charge differential (line 32 minus line 33)				34
35	Average per diem private private room cost differential (line 34 × line 31)				35
36	Private room cost differential adjustment (line 3 × line 35)				36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			33,761,633	37

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COMPUTATION OF INPATIENT OPERATING COST	PROVIDER NO: 420065	PERIOD: FROM 01/01/2010 TO 12/31/2010	WORKSHEET D-1, PART II

Medicare -Title XVIII - Hospital - 420065

	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	1	
38	Adjusted general inpatient routine service cost per diem (see instructions)	1,085.06	38
39	Program general inpatient routine service cost (line 9 × line 38)	13,148,757	39
40	Medically necessary private room cost applicable to the Program (line 14 × line 35)		40
41	Total Program general inpatient routine service cost (line 39 + line 40)	13,148,757	41

		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 × col. 4)	
		1	2	3	4	5	
42	Nursery (title V & XIX only)	3,503,282					42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit	4,114,512	2,462	1671.21	1,213	2,027,178	43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47.00	Other Special Care (specify)						47.00

		1	
48	Program inpatient ancillary service cost (Wkst. D-4, col. 3, line 101)	13,715,380	48
49	Total Program inpatient costs (sum of lines 41 through 48) (see instructions)	28,891,315	49
	PASS THROUGH COST ADJUSTMENTS		
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	2,164,548	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	1,095,160	51
52	Total Program excludable cost (sum of lines 50 and 51)	3,259,708	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist, and medical education costs (line 49 minus line 52)	25,631,607	53
	TARGET AMOUNT AND LIMIT COMPUTATION		
54	Program discharges		54
55	Target amount per discharge		55
56	Target amount (line 54 × line 55)		56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57
58	Bonus payment (see instructions)		58
58.01	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket		58.01
58.02	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket		58.02
58.03	If lines 53/54 is less than the lower of lines 55, 58.01 or 58.02 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 × 58.02), or 1 percent of the target amount (line 56), otherwise enter zero		58.03
58.04	Relief payment (see instructions)		58.04
59	Allowable inpatient cost plus incentive payment (see instructions)		59
	PROGRAM INPATIENT ROUTINE SWING BED COST		
60	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (line 10 × line 17) (title XVIII only)		60
61	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (line 11 × line 18) (title XVIII only)		61
62	Total Medicare swing-bed SNF inpatient routine cost (line 60 plus line 61) (title XVIII)		62
63	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 × line 19)		63
64	Title V or XIX swing-bed NF inpatient routine cst after December 31 of the cost reporting period (line 13 × line 20)		64
65	Total title V or XIX swing-bed NF inpatient routine costs (line 63 + line 64)		65

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COMPUTATION OF INPATIENT OPERATING COST	PROVIDER NO: 420065	PERIOD: FROM 01/01/2010 TO 12/31/2010	WORKSHEET D-1, PART II

Medicaid - Title XIX - Hospital - 420065

	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	1	
38	Adjusted general inpatient routine service cost per diem (see instructions)	1,085.06	38
39	Program general inpatient routine service cost (line 9 × line 38)	2,282,966	39
40	Medically necessary private room cost applicable to the Program (line 14 × line 35)		40
41	Total Program general inpatient routine service cost (line 39 + line 40)	2,282,966	41

		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 × col. 4)	
		1	2	3	4	5	
42	Nursery (title V & XIX only)	3,503,282	4,629	756.81	457	345,862	42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit	4,114,512	2,462	1671.21	194	324,215	43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47.00	Other Special Care (specify)						47.00

		1	
48	Program inpatient ancillary service cost (Wkst. D-4, col. 3, line 101)	2,043,275	48
49	Total Program inpatient costs (sum of lines 41 through 48) (see instructions)	4,996,318	49
	PASS THROUGH COST ADJUSTMENTS		
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)		50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51
52	Total Program excludable cost (sum of lines 50 and 51)		52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist, and medical education costs (line 49 minus line 52)		53
	TARGET AMOUNT AND LIMIT COMPUTATION		
54	Program discharges		54
55	Target amount per discharge		55
56	Target amount (line 54 × line 55)		56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57
58	Bonus payment (see instructions)		58
58.01	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket		58.01
58.02	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket		58.02
58.03	If lines 53/54 is less than the lower of lines 55, 58.01 or 58.02 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 × 58.02), or 1 percent of the target amount (line 56), otherwise enter zero		58.03
58.04	Relief payment (see instructions)		58.04
59	Allowable inpatient cost plus incentive payment (see instructions)		59
	PROGRAM INPATIENT ROUTINE SWING BED COST		
60	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (line 10 × line 17) (title XVIII only)		60
61	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (line 11 × line 18) (title XVIII only)		61
62	Total Medicare swing-bed SNF inpatient routine cost (line 60 plus line 61) (title XVIII)		62
63	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 × line 19)		63
64	Title V or XIX swing-bed NF inpatient routine cst after December 31 of the cost reporting period (line 13 × line 20)		64
65	Total title V or XIX swing-bed NF inpatient routine costs (line 63 + line 64)		65

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COMPUTATION OF INPATIENT OPERATING COST	PROVIDER NO: 420065	PERIOD: FROM 01/01/2010 TO 12/31/2010	WORKSHEET D-1, PARTS III & IV

Medicare -Title XVIII - Hospital - 420065

PART III - SKILLED NURSING FACILITY, NURSING FACILITY AND ICF/MR ONLY

66	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)		66
67	Adjusted general inpatient routine service cost per diem (line 66 ÷ line 2)		67
68	Program routine service cost (line 9 × line 67)		68
69	medically necessary private room cost applicable to Program (line 14 × line 35)		69
70	Total Program general inpatient routine service costs (line 68 + line 69)		70
71	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, sum of Parts II and III, column 27)		71
72	Per diem capital-related costs (line 71 ÷ line 2)		72
73	Program capital-related costs (line 9 × line 72)		73
74	Inpatient routine service cost (line 70 minus line 73)		74
75	Aggregate charges to beneficiaries for excess costs (from provider records)		75
76	Total Program routine services costs for comparison to the cost limitation (line 74 minus line 75)		76
77	Inpatient routine service cost per diem limitation		77
78	Inpatient routine service cost limitation (line 9 × line 77)		78
79	Reasonable inpatient routine service costs (see instructions)		79
80	Program inpatient ancillary services (see instructions)		80
81	Utilization review - physician compensation		81
82	Total Program inpatient operating costs (sum of lines 79 through 81)		82

PART IV - PART IV - COMPUTATION OF OBSERVATION BED COST

83	Total observation bed days (see instructions)	1,242	83
84	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,085.06	84
85	Observation bed cost (line 83 × line 84) (see instructions)	1,347,645	85

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

		Cost	Routine Cost (from line 27)	col. 1 ÷ col. 2	Total Observation Bed Cost (from line 85)	Observation Bed Pass Through Cost (col. 3 × col. 4) (see instructions)	
		1	2	3	4	5	
86	Old capital-related cost		33,761,633		1,347,645		86
87	New capital-related cost	4,999,001	33,761,633	0.148068	1,347,645	199,543	87
88	Non Physician Anesthetist		33,761,633		1,347,645		88
89	Medical Education	133,256	33,761,633	0.003947	1,347,645		89

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COMPUTATION OF INPATIENT OPERATING COST	PROVIDER NO: 420065	PERIOD: FROM 01/01/2010 TO 12/31/2010	WORKSHEET D-1, PARTS III & IV

Medicaid - Title XIX - Hospital - 420065

PART III - SKILLED NURSING FACILITY, NURSING FACILITY AND ICF/MR ONLY

66	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)		66
67	Adjusted general inpatient routine service cost per diem (line 66 ÷ line 2)		67
68	Program routine service cost (line 9 × line 67)		68
69	medically necessary private room cost applicable to Program (line 14 × line 35)		69
70	Total Program general inpatient routine service costs (line 68 + line 69)		70
71	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, sum of Parts II and III, column 27)		71
72	Per diem capital-related costs (line 71 ÷ line 2)		72
73	Program capital-related costs (line 9 × line 72)		73
74	Inpatient routine service cost (line 70 minus line 73)		74
75	Aggregate charges to beneficiaries for excess costs (from provider records)		75
76	Total Program routine services costs for comparison to the cost limitation (line 74 minus line 75)		76
77	Inpatient routine service cost per diem limitation		77
78	Inpatient routine service cost limitation (line 9 × line 77)		78
79	Reasonable inpatient routine service costs (see instructions)		79
80	Program inpatient ancillary services (see instructions)		80
81	Utilization review - physician compensation		81
82	Total Program inpatient operating costs (sum of lines 79 through 81)		82

PART IV - PART IV - COMPUTATION OF OBSERVATION BED COST

83	Total observation bed days (see instructions)	1,242	83
84	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,085.06	84
85	Observation bed cost (line 83 × line 84) (see instructions)	1,347,645	85

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

		Cost	Routine Cost (from line 27)	col. 1 ÷ col. 2	Total Observation Bed Cost (from line 85)	Observation Bed Pass Through Cost (col. 3 × col. 4) (see instructions)	
		1	2	3	4	5	
86	Old capital-related cost		33,761,633		1,347,645		86
87	New capital-related cost		33,761,633		1,347,645		87
88	Non Physician Anesthetist		33,761,633		1,347,645		88
89	Medical Education		33,761,633		1,347,645		89

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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	PROVIDER NO: 420065	PERIOD: FROM 01/01/2010 TO 12/31/2010	WORKSHEET D-4

Medicare -Title XVIII - Hospital - 420065

	COST CENTER DESCRIPTION	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 × col. 2)	
		1	2	3	
(A)	INPATIENT ROUTINE SERVICE COST CENTERS				
25	Adults and Pediatrics (General Routine Care)		17,654,420		25
26	Intensive Care Units		4,109,295		26
27	Coronary Care Unit				27
28	Burn Intensive Care Unit				28
29	Surgical Intensive Care Unit				29
30.00	Other Special Care (specify)				30.00
31.00	Subprovider				31.00
	ANCILLARY SERVICE COST CENTERS				
37.05	Operating Room	0.243331	11,404,503	2,775,069	37.05
38	Recovery Room	0.174419	1,086,375	189,484	38
39.05	Delivery Room & Labor Room	0.302424	11,174	3,379	39.05
40.00	Anesthesiology				40.00
41.05	Radiology-Diagnostic	0.107530	6,728,201	723,483	41.05
42.00	Radiology-Therapeutic				42.00
43	Radioisotope				43
44.05	Laboratory	0.083049	15,951,997	1,324,797	44.05
44.10	Oncology	0.412683			44.10
44.45	Vascular Lab	0.115849	723,635	83,832	44.45
45	PBP Clinic Laboratory Services-Program Only				45
46.00	Whole Blood & Packed Red Blood Cells				46.00
47	Blood Storing, Processing, & Transfusing	0.241345	2,208,570	533,027	47
48	Intravenous Therapy				48
49.05	Respiratory Therapy	0.345415	2,745,203	948,234	49.05
50.05	Physical Therapy	0.397261	1,227,024	487,449	50.05
51	Occupational Therapy				51
52	Speech Pathology				52
53.05	Electrocardiology	0.128126	1,601,205	205,156	53.05
54	Electroencephalography				54
55	Medical Supplies Charged to Patients				55
55.30	Implantable Devices Charged to Patients	0.423508	5,593,474	2,368,881	55.30
56	Drugs Charged to Patients	0.249866	12,574,066	3,141,832	56
57	Renal Dialysis				57
58	ASC (Non-Distinct Part)				58
59.30	Other Ancillary Cost Centers	1.029525	261,085	147,057	59.30
	OUTPATIENT SERVICE COST CENTERS				
60.00	Clinic				60.00
61	Emergency	0.151401	5,176,321	783,700	61
62.10	Observation Beds (Non-DistinctPart)	0.880826			62.10
63.00	Other Outpatient Service (specify)				63.00
	OTHER REIMBURSABLE COST CENTERS				
64	Home Program Dialysis				64
65	Ambulance				65
66.00	Durable Medical Equipment-Rented				66.00
67.00	Durable Medical Equipment-Sold				67.00
68	Other Reimbursable (specify)				68
101	Total (sum of lines 37-64 and 66-68)		67,292,833	13,715,380	101
102	Less PBP Clinic Laboratory Services-Program only charges (line 45)				102
103	Net Charges (line 101 minus line 102)		67,292,833		103

(A) Worksheet A line numbers

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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	PROVIDER NO: 420065	PERIOD: FROM 01/01/2010 TO 12/31/2010	WORKSHEET D-4

Medicaid - Title XIX - Hospital - 420065

	COST CENTER DESCRIPTION	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 × col. 2)	
		1	2	3	
(A)	**INPATIENT ROUTINE SERVICE COST CENTERS**				
25	Adults and Pediatrics (General Routine Care)		3,370,155		25
26	Intensive Care Units		651,510		26
27	Coronary Care Unit				27
28	Burn Intensive Care Unit				28
29	Surgical Intensive Care Unit				29
30.00	Other Special Care (specify)				30.00
31.00	Subprovider				31.00
	ANCILLARY SERVICE COST CENTERS				
37.05	Operating Room	0.243331	1,049,981	255,493	37.05
38	Recovery Room	0 174419	123,452	21,532	38
39.05	Delivery Room & Labor Room	0.302424	2,567,630	776,513	39.05
40.00	Anesthesiology				40.00
41.05	Radiology-Diagnostic	0.107530	443,649	47,706	41.05
42.00	Radiology-Therapeutic				42.00
43	Radioisotope				43
44.05	Laboratory	0.083049	1,634,500	135,744	44.05
44.10	Oncology	0.412683			44.10
44.45	Vascular Lab	0.115849	38,987	4,517	44.45
45	PBP Clinic Laboratory Services-Program Only				45
46.00	Whole Blood & Packed Red Blood Cells				46.00
47	Blood Storing, Processing, & Transfusing	0.241345	317,907	76,725	47
48	Intravenous Therapy				48
49.05	Respiratory Therapy	0.345415	174,859	60,399	49.05
50.05	Physical Therapy	0.397261	55,317	21,975	50.05
51	Occupational Therapy				51
52	Speech Pathology				52
53.05	Electrocardiology	0.128126	62,818	8,049	53.05
54	Electroencephalography				54
55	Medical Supplies Charged to Patients				55
55.30	Implantable Devices Charged to Patients	0.423508	406,522	172,165	55.30
56	Drugs Charged to Patients	0.249866	1,509,571	377,190	56
57	Renal Dialysis				57
58	ASC (Non-Distinct Part)				58
59.30	Other Ancillary Cost Centers	1.029525	10,747	6,053	59.30
	OUTPATIENT SERVICE COST CENTERS				
60.00	Clinic				60.00
61	Emergency	0.151401	523,208	79,214	61
62.10	Observation Beds (Non-DistinctPart)	0.880826			62.10
63.00	Other Outpatient Service (specify)				63.00
	OTHER REIMBURSABLE COST CENTERS				
64	Home Program Dialysis				64
65	Ambulance				65
66.00	Durable Medical Equipment-Rented				66.00
67.00	Durable Medical Equipment-Sold				67.00
68	Other Reimbursable (specify)				68
101	Total (sum of lines 37-64 and 66-68)		8,919,148	2,043,275	101
102	Less PBP Clinic Laboratory Services-Program only charges (line 45)				102
103	Net Charges (line 101 minus line 102)		8,919,148		103

(A) Worksheet A line numbers

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	CALCULATION OF REIMBURSEMENT SETTLEMENT	PROVIDER NO: 420065	PERIOD: FROM: 01/01/2010 TO: 12/31/2010	WORKSHEET E, PART A	
Medicare -Title XVIII - Hospital - 420065					
	PART A - INPATIENT HOSPITAL SERVICES UNDER PPS		1	1.01	
	DRG Amount				
1	Other than Outlier Payments occurring prior to October 1		14,855,753		1
1.01	Other than Outlier Payments occurring on or after October 1 and before January 1		4,951,918		1.01
1.02	Other than Outlier Payments occurring on or after January 1				1.02
	Managed Care Patients				
1.03	Payments prior to March 1st or October 1st				1.03
1.04	Payments on or after October 1 and prior to January 1				1.04
1.05	Payments on or after January 1st but before April 1st/October 1st				1.05
1.06	Additional amount received or to be received (see instructions)				1.06
1.07	Payments for discharges on or after April 1, 2001 through September 30, 2001				1.07
1.08	Simulated payments from the PS&R on or afetr April 1, 2001 through September 30, 2001				1.08
2	Outlier payments for discharges occuring prior to October 1, 1997 (see instructions)				2
2.01	Outlier payments for discharges occurring on or after October 1, 1997 (see instructions)		393,179		2.01
	Indirect Medical Education Adjustment				
3	Bed days available divided by number of days in the cost reporting period (see instructions)		200.60		3
3.01	Number of Interns & Residents from Worksheet S-3, Part I				3.01
3.02	Indirect medical education percentage (see instructions)				3.02
3.03	Indirect medical education adjustment (sum of lines 1, 1.01, 1.02, and 2 times line 3.02)				3.03
3.04	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996				3.04
3.05	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with section 1886(d)(5)(B)(viii)				3.05
3.06	Adjusted FTE count for allopathic and osteopathic programs for affiliated programs in accordance with section 1886(d)(5)(B)(viii)				3.06
3.07	Sum of lines 3.04 through 3.06				3.07
3.08	FTE count for allopathic and osteopathic programs in the current year from your records				3.08
3.09	For cost reporting periods beginning before October 1, enter the percentage of discharges occurring prior to October 1				3.09
3.10	For cost reporting periods beginning before October 1, enter the percentage of discharges occurring on or after October 1				3.10
3.11	FTE count for the period identified in line 3.09				3.11
3.12	FTE count for the period identified in line 3.10				3.12
3.13	FTE count for residents in dental and podiatric programs				3.13
3.14	Current year allowable FTE (see instructions)				3.14
3.15	Total allowable FTE count for the prior year, if none but prior year teaching was in effect enter 1 here				3.15
3.16	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otehrwise enter zero. If there was no FTE count in this period but prior year teaching was in effect enter 1 here				3.16
3.17	Sum of lines 3.14 through 3.16 divided by the number of those lines in excess of zero (see instructions)				3.17
3.18	Current year residents to bed ratio (line 3.17 divided by line 3)				3.18
3.19	Prior year resident to bed ratio (see instructions)				3.19
3.20	For cost reporting periods beginning on or after October 1, 1997, enter the lesser of lines 3.18 or 3.19				3.20
3.21	IME payments for discharges occurring prior to October 1 (see instructions)				3.21
3.22	IME payments for discharges occurring on or after October 1 but before January 1 (see instructions)				3.22
3.23	IME payments for discharges occurring on or after January 1 (see instructions)				3.23
3.24	Sum of lines 3.21 through 3.23				3.24
	Disproportionate Share Adjustment				
4	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		0.093800		4
4.01	Percentage of Medicaid patient days to total days reported on Worksheet S-3, Part I		0.198500		4.01
4.02	Sum of lines 4 and 4.01		0.292300		4.02
4.03	Allowable disproportionate share percentage (see instructions)		0.133300		4.03
4.04	Disproportionate share adjustment (sum of lines 1, 1.01, 1.02, and 2 times line 4.03)		2,640,363		4.04
PART A - INPATIENT HOSPITAL SERVICES UNDER PPS					
	Additional payment for high percentage of ESRD beneficiary discharges				
5	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for DRGs 302, 316, 317 or MS-DRG 652, 682 - 685. (see instructions)				5
5.01	Total ESRD Medicare discharges excluding DRGs 302, 316, and 317, or MS-DRGs 652 and 682 - 685 (see instructions)				5.01
5.02	Divide line 5.01 by line 5 (if less than 10%, you do not qualify for adjustment)				5.02

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	CALCULATION OF REIMBURSEMENT SETTLEMENT	PROVIDER NO: 420065	PERIOD: FROM: 01/01/2010 TO: 12/31/2010	WORKSHEET E, PART A	
Medicare -Title XVIII - Hospital - 420065					
5.03	Total medicare ESRD inpatient days excluding DRGs 302, 316, 317, or MS-DRGs 652, 682 - 685.(see instructions)				5.03
5.04	Ratio of average length of stay to one week (line 5.03 divided by line 5.01 divided by 7)				5.04
5.05	Average weekly cost for dialysis treatments (see instructions)				5.05
5.06	Total additional payment (line 5.04 times line 5.05 times line 5.01)				5.06
6	Subtotal (see instructions)		22,841,213		6
7	Hospital specific payments (to be completed by SCH and MDC, small rural hospitals only)				7
7.01	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.See instructions FY beg. 10/1/00)				7.01
8	Total payment for inpatient operating costs (for SCH and MDH, small rural hospitals, higher of lines 6 or 7, all other providers, enter amount from line 6 on this line.)		22,841,213		8
9	Payment for inpatient program capital (from Worksheet L, parts I, II, or III, as applicable)		1,746,265		9
10	Exception payment for inpatient program capital (Worksheet L, Part IV, line 13)				10
11	Direct graduate medical eduation payment (from Worksheet E-3, Part IV)				11
11.01	Nursing and Allied Health Managed Care				11.01
11.02	Special add-on payments for new technologies				11.02
12	Net organ acquisition cost				12
13	Cost of teaching physicians				13
14	Routine service other pass through costs		59,677		14
15	Ancillary service other pass through costs		11,349		15
16	Total (sum of amounts on lines 8 through 15)		24,658,504		16
17	Primary payer payments		22,717		17
18	Total amount payable for program beneficiaries (line 16 minus line 17)		24,635,787		18
19	Deductibles billed to program beneficiaries		2,105,540		19
20	Coinsurance billed program beneficiaries		98,800		20
21	Reimbursable bad debts (see instructions)		296,122		21
21.01	Adjusted reimbursable bed debts (see instructions)		207,285		21.01
21.02	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		61,178		21.02
22	Subtotal (line 18 plus line 21.01 minus lines 19 and 20)		22,638,732		22
23	Recovery of excess depreciation resulting from provider termination or a decrease in program utilization				23
24	Other adjustments (see instructions) (specify)				24
24.99	Other adjustments - Outlier reconsiliation				24.99
25	Amounts applicable to prior cost reporting periods resulting from disposition of depreciable assets)				25
26	Amount due provider (line 22 plus or minus lines 24 and 25 minus line 23)		22,638,732		26
27	Sequestration adjustment (see instructions)				27
28	Interim payments		22,894,505		28
28.01	Tentative settlement (for fiscal intermediary use only)				28.01
29	Balance due provider (Program) (line 26 minus the sum of lines 27, 28, and 28.01)		-255,773		29
30	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2				30
TO BE COMPLETED BY INTERMEDIARY					
50	Operating outlier amount from Worksheet E, Part A line 2.01				50
51	Capital outlier amount from Worksheet L, Part I line 3.01				51
52	Operating outlier reconciliation adjustment amount (see instructions)				52
53	Capital outlier reconciliation adjustment amount (see instructions)				53
54	The rate used to calculate the Time Value of Money (see instructions)				54
55	Operating Time Value of Money (see instructions)				55
56	Capital Time Value of Money (see instructions)				56

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	CALCULATION OF REIMBURSEMENT SETTLEMENT	PROVIDER NO: 420065	PERIOD: FROM 01/01/2010 TO 12/31/2010	WORKSHEET E PART B	
Medicare -Title XVIII - Hospital - 420065					
PART B - MEDICAL AND OTHER HEALTH SERVICES					
1	Medical and other services (see instructions)				1
1.01	Medical and other services rendered on or after August 1, 2000 from Worksheet D, Part V, column 9.01, line 104			14,076,964	1.01
1.02	PPS payments received including outliers			13,922,926	1.02
1.03	Enter the 1996 hospital specific payment to cost ratio				1.03
1.04	Line 1.01 times line 1.03				1.04
1.05	Line 1.02 divided by line 1.04				1.05
1.06	Transitional corridor payment (see instructions)				1.06
1.07	Enter the amount from Worksheet D, Part IV, column 9, line 101			17,376	1.07
2	Interns and residents				2
3	Organ acquisitions				3
4	Cost of teaching physicians				4
5	Total cost (see instructions)				5
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable charges				
6	Ancillary service charges				6
7	Interns and residents service charges				7
8	Organ acquisition charges (from Worksheet D-6, Part III, line 61, col. 4)				8
9	Charges of professional services of teaching physicians				9
10	Total reasonable charges (sum of lines 6 through 9)				10
	Customary charges				
11	Aggregate amount actually collected from patients liable for payment for services on a charge basis				11
12	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)				12
13	Ratio of line 11 to line 12 (not to exceed 1.000000)				13
14	Total customary charges (see instructions)				14
15	Excess of customary chages over reasonable cost (complete only if line 14 exceeds line 5) (see instructions)				15
16	Excess of reasonable cost over customary charges (complete only if line 5 exceeds line 14) (see instructions)				16
17	Lesser of cost or charges (line 5 or line 14) (see instructions)				17
17.01	Total prospective payment (sum of lines 1.01, 1.06, 1.07)			13,940,302	17.01
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18	Deductibles and coinsurance (see instructions)				18
18.01	Coinsurance relating to amount on line 17.01			3,090,845	18.01
19	Subtotal (line 17 minus line 18)			10,849,457	19
20	Sum of amounts from Worksheet E, Parts C, D, and E (see instructions)				20
21	Direct graduate medical education payments (from Worksheet E-3, Part IV)				21
22	ESRD direct medical education costs (from Worksheet E-3, Part IV)				22
23	Subtotal (sum of lines 19 through 22)			10,849,457	23
24	Primary payer payments			4,988	24
25	Subtotal (line 23 minus line 24)			10,844,469	25
	Reimbursable bad debts (exclude bad debts for professional services)				
26	Composite rate ESRD (from Worksheet I-5, line 9)				26
27	Bad debts (see instructions)			411,704	27
27.01	Adjusted reimbursable bad debts (see instructions)			288,193	27.01
27.02	Reimbursable bad debts for dual eligible beneficiaries			238,111	27.02
28	Subtotal (sum of lines 25, 26, and 27 or 27.01) (line 27.01 hospital and subprovider only)			11,132,662	28
29	Recovery of excess depreciation resulting from provider termination or a decrease in program utilization				29
30	Other adjustments (specify) (see instructions)				30
31	Amounts applicable to prior cost reporting periods resulting from disposition of depreciable assets				31
32	Subtotal (line 28 plus or minus lines 30 and 31 minus line 29)			11,132,662	32
33	Sequestration adjustment (see instructions)				33
34	Interim payments			11,295,275	34
34.01	Tentative settlement (for fiscal intermediary use only)				34.01
35	Balance due provider/program (line 32 minus the sum of lines 33, 34, and 34.01)			-162,613	35
36	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2				36
TO BE COMPLETED BY CONTRACTOR					
50	Original outlier amount (see instructions)				50
51	Outlier reconciliation amount (see instructions)				51

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	CALCULATION OF REIMBURSEMENT SETTLEMENT	PROVIDER NO: 420065	PERIOD: FROM 01/01/2010 TO 12/31/2010	WORKSHEET E PART B	
Medicare -Title XVIII - Hospital - 420065					
52	The rate used to calculate the Time Value of Money				52
53	Time Value of Money (see instructions)				53
54	Total (sum of lines 51 and 53)				54

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	CALCULATION OF REIMBURSEMENT SETTLEMENT	PROVIDER NO: 420065	PERIOD: FROM: 01/01/2010 TO: 12/31/2010	WORKSHEET E-3 PART III	
Medicaid - Title XIX - Hospital - 420065					
	COMPUTATION OF NET COST OF COVERED SERVICES		Title V or Title XIX	Title XVIII SNF PPS	
			1	2	
1	Inpatient hospital/SNF/NF services		4,996,318		1
2	Medical and other services		1,325,186		2
3	Interns and residents (see instructions)				3
4	Organ acquisition (certified transplant centers only)				4
5	Cost of teaching physicians (see instructions)				5
6	Subtotal (sum of lines 1 through 5)		6,321,504		6
7	Inpatient primary payer payments				7
8	Outpatient primary payer payments				8
9	Subtotal (line 6 less sum of lines 7 and 8)		6,321,504		9
COMPUTATION OF LESSER OF COST OR CHARGES					
	REASONABLE CHARGES				
10	Routine service charges				10
11	Ancillary service charges		17,403,736		11
12	Interns and residents service charges				12
13	Organ acquisition charges, net of revenue				13
14	Teaching physicians				14
15	Incentive from target amount computation				15
16	Total reasonable charges (sum of lines 10 through 15)		17,403,736		16
	CUSTOMARY CHARGES				
17	Amount actually collected from patients liable for payment for services on a charge basis				17
18	Amounts that would have been realized from patients liable for payment for a on charge basis had such payment been made in accordance with 42 CFR 4				18
19	Ratio of line 17 to line 18 (not to exceed 1.000000)				19
20	Total customary charges (see instructions)		17,403,736		20
21	Excess of customary charges over reasonable cost (complete only if line 20 exceeds line 9) (see instructions)		11,082,232		21
22	Excess of reasonable cost over customary charges (complete only if line 9 exceeds line 20) (see instructions)				22
23	Cost of covered services (line 9)		6,321,504		23
24	Other than outlier payments				24
25	Outlier payments				25
26	Program capital payments				26
27	Capital exception payments				27
28	Routine service other pass through costs				28
29	Ancillary service other pass through costs				29
30	Subtotal (sum of lines 23 through 29)		6,321,504		30
31	Customary charges (title XIX PPS covered services only)				31
32	Titles V or XIX PPS, lesser of lines 30 or 31; non PPS and title XVIII enter a		6,321,504		32
33	Deductibles (exclude professional component)				33
34	Excess of reasonable cost (from line 22)				34
35	Subtotal (line 32 minus sum of lines 33 and 34)		6,321,504		35
36	Coinsurance				36
37	Sum of the amounts from Wkst. E, Parts C, D, and E, line 19				37
38	Reimbursable bad debts (see instructions)				38
38.01	Adjusted reimbursable bad debts (see instructions)				38.01
38.02	Reimbursable bad debts for dual eligible beneficiaries				38.02
38.03	Adjusted reimbursable bad debts for periods ending on or after 10/01/05 (see instructions)				38.03
39	Utilization review				39
40	Subtotal (see instructions)		6,321,504		40
41	Inpatient routine service cost (Wkst. D-1, Part III, line 70)				41
42	Medicare inpatient routine charges (from your records)				42
43	Amount actually collected from patients liable for payment for services on a charge basis (see instructions)				43
44	Amounts that would have been realized from patients liable for payment of Part A services (see instructions)				44
45	Ratio of line 43 to line 44 (not to exceed 1.000000)				45
46	Total customary charges (see instructions)				46

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	CALCULATION OF REIMBURSEMENT SETTLEMENT	PROVIDER NO: 420065	PERIOD: FROM: 01/01/2010 TO: 12/31/2010	WORKSHEET E-3 PART III	
Medicaid - Title XIX - Hospital - 420065					
	COMPUTATION OF NET COST OF COVERED SERVICES		Title V or Title XIX	Title XVIII SNF PPS	
			1	2	
47	Excess of customary charges over reasonable cost (see instructions)				47
48	Excess of reasonable cost over customary charges (see instructions)				48
49	Recovery of excess depreciation resulting from provider termination or a decrease in program utilization				49
50	Other adjustments (see instructions) (specify)				50
51	Amounts applicable to prior cost reporting periods resulting from disposition of depreciable assets				51
52	Subtotal (line 40 ± lines 50 and 51, minus line 49)		6,321,504		52
53	Indirect medical education adjustment (PPS only) (see instructions)				53
54	Direct graduate medical education payments (from Wkst. E-3, Part IV)				54
55	Total amount payable to the provider (sum of lines 52, 53, and 54)		6,321,504		55
56	Sequestration adjustment (see instructions)				56
57	Interim payments		6,214,098		57
57.01	Tentative settlement (for fiscal intermediary use only)				57.01
58	Balance due provider/program (line 55 minus the sum of lines 56, 57, and 57.01)		107,406		58
59	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2				59

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ST. FRANCIS XAVIER BON SECOURS - CHARLESTON, SC
Cost report status - As Submitted
[Record code 267623 - 1996]

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)		PROVIDER NO: 420065	PERIOD: FROM 01/01/2010 TO 12/31/2010	WORKSHEET G	
	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	1	2	3	4	
CURRENT ASSETS					
1 Cash on hand and in banks	5,200				1
2 Temporary investments			20,000		2
3 Notes receivable					3
4 Accounts receivable	24,974,183				4
5 Other receivables	2,476,833				5
6 Allowances for uncollectible notes and accounts receivable					6
7 Inventory	2,685,262				7
8 Prepaid expenses					8
9 Other current assets					9
10 Due from other funds	113,876,240				10
11 Total current assets (sum of lines 1-10)	144,017,718		20,000		11
FIXED ASSETS					
12 Land	13,580,943				12
13 Land improvements	3,222,576				13
13.01 Accumulated depreciation	1,597,374				13.01
14 Buildings	116,029,981				14
14.01 Accumulated depreciation	23,621,506				14.01
15 Leasehold improvements	1,405,978				15
15.01 Accumulated depreciation	581,702				15.01
16 Fixed equipment	4,885,562				16
16 01 Accumulated depreciation	4,310,140				16.01
17 Automobiles and trucks					17
17.01 Accumulated depreciation					17.01
18 Major movable equipment	38,586,739				18
18 01 Accumulated depreciation	23,883,150				18.01
19 Minor equipment depreciable	461,728				19
19.01 Accumulated depreciable	428,386				19.01
20 Minor equipment-nondepreciable					20
21 Total fixed assets (sum of lines 12-20)	123,751,249				21
OTHER ASSETS					
22 Investments	464,387				22
23 Deposits on leases					23
24 Due from owners/officers					24
25 Other assets	949,167				25
26 Total other assets (sum of lines 22-25)	1,413,554				26
27 Total assets (sum of lines 11, 21, and 26)	269,182,521		20,000		27
CURRENT LIABILITIES					
28 Accounts payable	712,128				28
29 Salaries, wages, and fees payable	386,179				29
30 Payroll taxes payable					30
31 Notes and loans payable (short term)					31
32 Deferred income					32
33 Accelerated payments					33
34 Due to other funds	-75,201,410				34
35 Other current liabilities	6,254,164				35
36 Total current liabilities (sum of lines 28 thru 35)	-67,848,939				36
LONG TERM LIABILITIES					

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BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)			PROVIDER NO 420065	PERIOD: FROM 01/01/2010 TO 12/31/2010	WORKSHEET G	
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1	2	3	4	
37	Mortgage payable					37
38	Notes payable	17,386,043				38
39	Unsecured loans					39
40	Loans from owners 40.01 Prior to 7/1/66 40.02 On or after 7/1/66					40.01
						40.02
41	Other long term liabilities	7,113				41
42	Total long term liabilities (sum of lines 37 thru 41)	17,393,156				42
43	Total liabilities (sum of lines 36 and 42)	-50,455,783				43
	CAPITAL ACCOUNTS					
44	General fund balance	319,638,304				44
45	Specific purpose fund					45
46	Donor created - endowment fund balance - restricted			20,000		46
47	Donor created - endowment fund balance - unrestricted					47
48	Governing body created - endowment fund balance					48
49	Plant fund balance - invested in plant					49
50	Plant fund balance - reserve for plant improvement, replacement, and expansion					50
51	Total fund balances (sum of lines 44 thru 50)	319,638,304		20,000		51
52	Total liabilities and fund balances (sum of lines 43 and 51)	269,182,521		20,000		52

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ST. FRANCIS XAVIER BON SECOURS - CHARLESTON, SC
Cost report status - As Submitted
[Record code 267623 - 1996]

STATEMENT OF PATIENT REVENUES AND OPERATING REVENUES	PROVIDER NO: 420065	PERIOD: FROM 01/01/2010 TO 12/31/2010	WORKSHEET G-2 PARTS I & II

PART I - PATIENT REVENUES

	REVENUE CENTER	INPATIENT	OUTPATIENT	TOTAL	
		1	2	3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	Hospital	63,339,645		63,339,645	1
2.00	Subprovider				2.00
4	Swing bed - SNF				4
5	Swing bed - NF				5
6	Skilled nursing facility				6
7	Nursing facility				7
8	Other long term care				8
9	Total general inpatient care services (sum of lines 1-8)	63,339,645		63,339,645	9
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
10	Intensive care unit	8,225,419		8,225,419	10
11	Coronary care unit				11
12	Burn intensive care unit				12
13	Surgical intensive care unit				13
14.00	Other Special Care (specify)				14.00
15	Total intensive care type inpatient hospital services (sum of lines 10-14)	8,225,419		8,225,419	15
16	Total inpatient routine care services (sum of lines 9 and 15)	71,565,064		71,565,064	16
17	Ancillary services	152,278,693		152,278,693	17
18	Outpatient services		272,231,190	272,231,190	18
19	Home health agency				19
20	Ambulance				20
21	Outpatient rehabilitation providers				21
22	ASC				22
23	Hospice				23
24		40,512	355,037	395,549	24
25	Total patient revenues (sum of lines 16-24) (transfer column 3 to Wkst. G-3, line 1)	223,884,269	272,586,227	496,470,496	25

PART II - OPERATING EXPENSES

		1	2	
26	Operating expenses (per Wkst. A, column 3, line 101)		129,080,011	26
27	Add (specify)			27
28				28
29				29
30				30
31				31
32				32
33	Total additions (sum of lines 27-32)			33
34	Deduct (specify)			34
35				35
36				36
37				37
38				38
39	Total deductions (sum of lines 34-38)			39
40	Total operating expenses (sum of lines 26 and 33 minus line 39) (transfer to Wkst. G-3, line 4)		129,080,011	40

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ST. FRANCIS XAVIER BON SECOURS - CHARLESTON, SC
Cost report status - As Submitted
[Record code 267623 - 1996]

STATEMENT OF REVENUES AND EXPENSES	PROVIDER NO: 420065	PERIOD: FROM 01/01/2010 TO 12/31/2010	WORKSHEET G-3	
	Description			
1	Total patient revenues (from Wkst. G-2, Part I, column 3, line 25)		496,470,496	1
2	Less contractual allowances and discounts on patients' accounts		333,359,837	2
3	Net patient revenues (line 1 minus line 2)		163,110,659	3
4	Less total operating expenses (from Wkst. G-2, Part II, line 40)		129,080,011	4
5	Net income from service to patients (line 3 minus line 4)		34,030,648	5
OTHER INCOME				
6	Contributions, donations, bequests, etc.			6
7	Income from investments			7
8	Revenues from telephone and telegraph service			8
9	Revenue from television and radio service			9
10	Purchase discounts			10
11	Rebates and refunds of expenses			11
12	Parking lot receipts			12
13	Revenue from laundry and linen service			13
14	Revenue from meals sold to employees and guests		923,486	14
15	Revenue from rental of living quarters			15
16	Revenue from sale of medical and surgical supplies to other than patients			16
17	Revenue from sale of drugs to other than patients			17
18	Revenue from sale of medical records and abstracts		1,198	18
19	Tuition (fees, sales of textbooks, uniforms, etc.)			19
20	Revenue from gifts, flowers, coffee shops, and canteen		50,526	20
21	Rental of vending machines			21
22	Rental of hospital space			22
23	Governmental appropriations			23
24	Other (specify)		1,552,557	24
25	Total other income (sum of lines 6-24)		2,527,767	25
26	Total (line 5 plus line 25)		36,558,415	26
27	Other expenses (specify)		849,375	27
28				28
29				29
30	Total other expenses (sum of lines 27-29)		849,375	30
31	Net income (or loss) for the period (line 26 minus line 30)		35,709,040	31

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ST. FRANCIS XAVIER BON SECOURS - CHARLESTON, SC
Cost report status - As Submitted
[Record code 267623 - 1996]

Medicare -Title XVIII - Hospital - 420065				
CALCULATION OF CAPITAL PAYMENT	PROVIDER NO: 420065	PERIOD: FROM: 01/01/2010 TO: 12/31/2010	WORKSHEET L	
PART I - FULLY PROSPECTIVE METHOD				
1	Capital hospital specific rate payments			1
	Capital Federal Amount			
2	Capital DRG other than outlier		1,615,492	2
3	Capital DRG outlier payments for services rendered prior to October 1, 1997			3
3.01	Capital DRG outlier payments for services rendered on or after October 1, 1997		32,228	3.01
	Indirect Medical Education Adjustment			
4	Total inpatient days divided by number of days in the cost reporting period (see instructions)		88.59	4
4.01	Number of interns & residents (from Worksheet S-3, Part I, column 9, line 12)			4.01
4.02	Indirect medical education percentage (see instructions)			4.02
4.03	Indirect medical education adjustment (sum of lines 2 & 3 times line 4.02)			4.03
	Disproportionate Share Adjustment			
5	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		0	5
5.01	Percentage of Medicaid patient days to total days reported on Worksheet S-3, Part I (see instructions)		0.198500	5.01
5.02	Sum of lines 5 and 5.01		0.29	5.02
5.03	Allowable disproportionate share percentage (see instructions)		0.061000	5.03
5.04	Disproportionate share adjustment (sum of lines 2 & 3 times line 5.03)		98,545	5.04
6	Total prospective capital payments (sum of lines 1-3.01, 4.03, and 5.04)		1,746,265	6
PART II - HOLD HARMLESS METHOD				
1	New capital (see instructions)			1
2	Old capital (see instructions)			2
3	Total capital (sum of line 1 plus line 2)			3
4	Ratio of new capital to total capital (line 1 divided by line 3)			4
5	Total capital payments under 100% federal rate (see instructions)			5
6	Reduction factor for hold harmless payment (see instructions)			6
7	Reduced old capital amount (line 2 x line 6)			7
8	Hold harmless payment for new capital (line 5 x line 4)			8
9	Subtotal (line 7 plus line 8)			9
10	Payment under hold harmless (greater of line 5 or line 9)			10
PART III - PAYMENT UNDER REASONABLE COST				
1	Program inpatient routine capital cost (see instructions)			1
2	Program inpatient ancillary capital cost (see instructions)			2
3	Total inpatient program capital cost (line 1 plus line 2)			3
4	Capital cost payment factor (see instructions)			4
5	Total inpatient program capital cost (line 3 x line 4)			5
PART IV - COMPUTATION OF EXCEPTION PAYMENTS				
1	Program inpatient capital costs (see instructions)			1
2	Program inpatient capital costs for extraordinary circumstances (see instructions)			2
3	Net program inpatient capital costs (line 1 minus line 2)			3
4	Applicable exception percentage (see instructions)			4
5	Capital cost for comparison to payments (line 3 x line 4)			5
6	Percentage adjustment for extraordinary circumstances (see instructions)			6
7	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)			7
8	Capital minimum payment level (line 5 plus line 7)			8
9	Current year capital payments (from Part I, line 6 or Part II, line 10, as applicable)			9
10	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)			10
11	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part IV, line 14)			11
12	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)			12
13	Current year exception payment (if line 12 is positive, enter the amount on this line) for the following period (if line 12 is negative, enter the amount on this line)			13
14	Carryover of accumulated capital minimum payment level over capital payment			14
15	Current year allowable operating and capital payment (see instructions)			15
16	Current year operating and capital costs (see instructions)			16
17	Current year exception offset amount			17

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Cost Report data

420065
ST. FRANCIS XAVIER BON SECOURS
2095 HENRY TECKLENBURG DRIVE
CHARLESTON, SC 29414

[Electronic Record Code: 1927 - 2010]
Type of Facility: Short Term Acute Care
Type of Control: Voluntary Nonprofit, Other
Classification: Urban

Bed Size:	204
Total Annual Discharges:	8,618
Total Patient Revenue:	$574,300,736

Period: 01/01/2011 - 12/31/2011
Status: As Submitted

Fiscal Intermediary: Palmetto Government Benefits Administrators

Medicare Inpatient Characteristics

DSH Ratio:	0.106700
DSH Amount:	$2,391,518
Outlier Amount:	$692,390
IME Amount:	$0
GME Amount:	$0
Total IP Reimbursement:	$27,557,796
Total IP Costs:	$30,818,324
NPR Date:	00/00/0000
NPR Settlement Amount:	$25,213,032
NPR Settlement Percent:	91.49 %

[Date Generated: 03/20/2013]

Source
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Legend:

Identification
A hospital's Medicare provider number, name, and address are taken from Worksheet S-2. The Electronic Code is a code assigned by CostReportData.com to assist in resolving questions.

Type of Facility
The type of facility is determined from the last four digits of its Medicare provider number.

Type of Control
A hospital's type of control is taken from the HCRIS file.

Bed Size
The number of staffed beds is taken from Worksheet S-3, Part I, line 12, col.1. Cost report instructions define staffed beds as, "the number of beds available for use by patients at the end of the cost reporting period. A bed means an adult bed, pediatric bed, birthing room, or newborn bed maintained in a patient care area for lodging patients in acute, long term, or domiciliary areas of the hospital. Beds in labor room, birthing room, postanesthesia, postoperative recovery rooms, outpatient areas, emergency rooms, ancillary departments, nurses' and other staff residences, and other such areas which are regularly maintained and utilized for only a portion of the stay of patients (primarily for special procedures or not for inpatient lodging) are not termed a bed for these purposes.

Total Annual Discharges
The total number of inpatient discharges (all payors) is taken from Worksheet S-3, part I, line 12, column 15.

Total Patient Revenue
The total patient revenue (inpatient and outpatient) is taken from Worksheet G-2, part I, line 25, column 3.

Period
The beginning and ending dates for a cost report are taken from Worksheet S-2, line 17.

Status
The status of a cost report is taken from the HCRIS file.

Fiscal Intermediary
Medicare Fiscal Intermediaries (FIs) are private insurance companies that serve as the federal government's agents in the administration of the Medicare program, including the payment of claims. The name of the FI is obtained from a hospital's most recent Medicare cost report.

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Disproportionate Share (DSH Amount and DSH Ratio)
Medicare provides additional payment to hospitals that treat a disproportionate share of low-income patients. Qualifying hospitals receive a percentage increase in Medicare payments. This percentage increase varies depending on the ratio of low income patients and on certain statutory calculations. The Disproportionate SHare (DSH) ratio is taken from Worksheet E, Part A, line 4.03. The amount of DSH payments is from Worksheet E, Part A, line 4.04.

Outlier Amount
Medicare makes additional payments to hospitals for patients with costs that are extraordinarily high due to severity of illness and/or complicating conditions. The amount of outlier payments is from Worksheet E, Part A, line 2.01 (or line 2 for discharges occurring prior to October 1, 1997).

IME Amount
Teaching hospitals receive additional Medicare payment due to the indirect costs associated with medical education programs. These payments are intended to cover the costs of additional tests and procedures ordered by interns and residents over and above what would have been ordered by more experienced physicians. The amount of the Indirect Medical Education (IME) adjustment is from Worksheet E, Part A, line 3.24 (or line 3.03 for cost reporting periods ending on or before September 30, 1997).

GME Amount
Medicare pays a hospital for the costs of an approved direct Graduate Medical Education (GME) program. These costs include the direct cost of salaries and benefits for interns, residents, and teachers. The amount of GME payment is from Worksheet E, Part A, line 11.

Total IP Reimbursement
The total amount of Medicare inpatient reimbursement for the cost reporting period is from Worksheet E, Part A, line 16 for PPS hospitals or from Worksheet E-3, Part I, line 17 or Worksheet E-3, Part II, Line 30 for non-PPS hospitals.

Total IP Costs
Total IP Costs corresponding to Total IP Reimbursement are calculated in the cost report and summarized on Worksheet D-1, Part II, line 49.

NPR Date
At the close of its fiscal year, a provider must submit a cost report to the FI showing the costs it incurred during the fiscal year and the proportion of those costs to be allocated to Medicare. The FI reviews the cost report, determines the total amount of Medicare reimbursement due the provider and issues the provider a Notice of Program Reimbursement (NPR). The NPR date is obtained from the most recent cost report data (HCRIS). There is no NPR date for cost reports as submitted or as amended by the provider (see Status above).

NPR Settlement Amount
The NPR Settlement Amount is the Balance due provider/(Program). It is the difference between the Total IP Reimbursement (above) and the total interim payments for the cost reporting period less any tentative settlements previously made by the FI. The Balance due provider/(Program) is from Worksheet E, Part A, line 29 for PPS hospitals or from Worksheet E-3, Part I, line 20 or Worksheet E-3, Part II, Line 33 for non-PPS hospitals.

NPR Settlement Percentage
This NPR settlement percentage is the NPR settlement amount as a percentage of total inpatient reimbursement. (It is calculated from the data elements previously defined.)

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ST. FRANCIS XAVIER BON SECOURS - CHARLESTON, SC
Cost report status - As Submitted
[Record code 1927 - 2010]

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 420065	PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET S PARTS I, II & III
This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).		FORM APPROVED OMB NO. 0938-0050	

PART I - COST REPORT STATUS

Provider use only	1. [X] Electronically filed cost report		Date:	Time:
	2. [ ] Manually submitted cost report			
	3. [ ] 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. [1] Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended	6. Date Received: 05/30/2012	10. NPR Date:	
		7. Contractor No.: 11001	11. Contractor's Vendor Code: 4	
		8. [N] Initial Report for this Provider CCN	12. [ ] If line 5, column 1 is 4: Enter number of times reopened = 0-9.	
		9. [N] Final Report for this Provider CCN		

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 _____{Provider Name(s) and Number(s)} for the cost reporting period beginning _____ and ending _____ and to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services identified in this cost report were provided in compliance with such laws and regulations.

(Signed)	Name NOT AVAILIABLE ON ELECTRONIC FORM
	Officer or Administrator of Provider(s)
	Title NOT AVAILIABLE ON ELECTRONIC FORM
	Title
	_____
	Date

PART III - SETTLEMENT SUMMARY

		TITLE V	TITLE XVIII		HIT	TITLE XIX	
			PART A	PART B			
		1	2	3	4	5	
1	HOSPITAL		-710,726	-26,103		682,117	1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF						5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY						7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC						10
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER (Specify)						12
200	TOTAL		-710,726	-26,103		682,117	200

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 this 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 this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB 15-II, SECTIONS 4003.1-4003.3)

Rev. 2		40-503 - 08-11

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ST. FRANCIS XAVIER BON SECOURS - CHARLESTON, SC
Cost report status - As Submitted
[Record code 1927 - 2010]

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 420065	PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET S-10	
Uncompensated and indigent care cost computation				
1 Cost to charge ratio (Worksheet C, Part I line 200 column 3 divided by line 200 column 8)			0.232667	1
Medicaid (see instructions for each line)				
2 Net revenue from Medicaid			13,953,250	2
3 Did you receive DSH or supplemental payments from Medicaid?			Y	3
4 If line 3 is yes, does line 2 include all DSH or supplemental payments from Medicaid?			N	4
5 If line 4 is no, enter DSH or supplemental payments from Medicaid			2,327,442	5
6 Medicaid charges			62,241,228	6
7 Medicaid cost (line 1 times line 6)			14,481,480	7
8 Difference between net revenue and costs for Medicaid program (line 2 plus line 5 minus line 7)				8
State Children's Health Insurance Program (SCHIP) (see instructions for each line)				
9 Net revenue from stand-alone SCHIP				9
10 Stand-alone SCHIP charges				10
11 Stand-alone SCHIP cost (line 1 times line 10)				11
12 Difference between net revenue and costs for stand-alone SCHIP (line 9 minus line 11)				12
Other state or local government indigent care program (see instructions for each line)				
13 Net revenue from state or local indigent care program (not included on lines 2, 5 or 9)				13
14 Charges for patients covered under state or local indigent care program (not included in lines 6 or 10)				14
15 State or local indigent care program cost (line 1 times line 14)				15
16 Difference between net revenue and costs for state or local indigent care program (line 13 minus line 15)				16
Uncompensated care (see instructions for each line)				
17 Private grants, donations, or endowment income restricted to funding charity care				17
18 Government grants, appropriations or transfers for support of hospital operations				18
19 Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)				19
	Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
	1	2	3	
20 Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	29,215,116	6,148,302	35,363,416	20
21 Cost of initial obligation of patients approved for charity care (line 1 times line 20)	6,797,393	1,430,507	8,227,900	21
22 Partial payment by patients approved for charity care		274,786	274,786	22
23 Cost of charity care (line 21 minus line 22)	6,797,393	1,155,721	7,953,114	23
24 Does the amount in line 20, column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			N	24
25 If line 24 is yes, enter charges for patient days beyond an indigent care program's length of stay limit (see instructions)				25
26 Total bad debt expense for the entire hospital complex (see instructions)			17,546,664	26
27 Medicare bad debts for the entire hospital complex (see instructions)			333,208	27
28 Non-Medicare and non-reimbursable bad debt expense (line 26 minus line 27)			17,213,456	28
29 Cost of non-Medicare bad debt expense (line 1 times line 28)			4,005,003	29
30 Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)			11,958,117	30
31 Total unreimbursed and uncompensated care cost (line 19 plus line 30)			11,958,117	31

FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4012)

Rev. 2 | 40-523 - 08-11

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ST. FRANCIS XAVIER BON SECOURS - CHARLESTON, SC
Cost report status - As Submitted
[Record code 1927 - 2010]

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 420065	PERIOD: FROM 01/01/2011 TO 12/31/2011		WORKSHEET S-2 PART I	
Hospital and Hospital Health Care Complex Address:								
1	Street: 2095 HENRY TECKLENBURG DRIVE			P.O. Box:				1
2	City: CHARLESTON	State: SC	Zip Code: 29414	County: CHARLESTON				2

Hospital and Hospital-Based Component Identification:

	Component	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
	0	1	2	3	4	5	6	7	8	
3	Hospital	ST. FRANCIS XAVIER BON SECOURS	420065		1	10/01/1996	N	P	O	3
4	Subprovider- IPF									4
5	Subprovider- IRF									5
6	Subprovider- (Other)									6
7	Swing Beds-SNF						N	N	N	7
8	Swing Beds-NF						N		N	8
9	Hospital-Based SNF						N	N	N	9
10	Hospital-Based NF						N		N	10
11	Hospital-Based OLTC									11
12	Hospital-Based HHA						N	N	N	12
13	Separately Certified ASC						N	N	N	13
14	Hospital-Based Hospice									14
15	Hospital-Based Health Clinic-RHC						N	N	N	15
16	Hospital-Based Health Clinic-FQHC						N	N	N	16
17	Hospital-Based (CMHC)						N	N	N	17
17.10							N	N	N	17.10
17.20							N	N	N	17.20
17.30							N	N	N	17.30
17.40							N	N	N	17.40
18	Renal Dialysis									18
19	Other									19

20	Cost Reporting Period (mm/dd/yyyy)	From: 01/01/2011	To: 12/31/2011			20
21	Type of control (see instructions)	2				21

Inpatient PPS Information			
22	Does this facility qualify for and receive disproportionate share hospital payment in accordance with 42 CFR §412.106, or low income payment in accordance with 42 CFR §412.624 (e)(2)? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR §412.06 (c)(2) (Pickle amendment hospital)? In column 2, enter "Y" for yes or "N" for no.	Y	N	22
23	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N	23

		In-State Medicaid paid days	In-State Medicaid eligible days	Out-of State Medicaid paid days	Out-of State Medicaid eligible days	Medicaid HMO days	Other Medicaid days	
		1	2	3	4	5	6	
24	If line 22 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.	2,097	741			4,004		24
25	If line 22 is "yes", and this provider is an IRF then, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible days in col. 2, out-of-state Medicaid 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.							25

26	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
27	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter "1" for urban or "2" for rural.	1	27

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 420065	PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET S-2 PART I	

35	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.				35
36	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:		36
37	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.				37
38	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:		38

		V	XVIII	XIX	
	Prospective Payment System (PPS)-Capital	1	2	3	
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320? (see instructions)	N	Y	N	45
46	Is this facility eligible for the special exceptions payment pursuant to 42 CFR §412.348(g)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N	46
47	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47
48	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48

		1	2	3	
	Teaching Hospitals				
56	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56
57	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.	N			57
58	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
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59
60	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)	Y			60

		Y/N	IME Average	Direct GME Average	
61	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)	N			61

	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)				
62	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)				62
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)				62.01

	Teaching Hospitals that Claim Residents in Non-Provider Settings				
63	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

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
	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	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)				64

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1	2	3	4	5	
65	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)						65

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings–Effective for cost reporting periods beginning on or after July 1, 2010	1	2	3	
66	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)				66

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 420065	PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET S-2 PART I		

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1	2	3	4	5	
67	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)						67

Inpatient Psychiatric Facility PPS			1	2	3	
70	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.		N			70
71	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)					71
Inpatient Rehabilitation Facility PPS						
75	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes or "N" for no.		N			75
76	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)					76
Long Term Care Hospital PPS						
80	Is this a Long Term Care Hospital (LTCH)? Enter "Y" for yes or "N" for no.			N		80
TEFRA Providers						
85	Is this a new hospital under 42 CFR §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N		85
86	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR §413.40(f)(1)(ii)? Enter "Y" for yes or "N" for no.			N		86
				V	XIX	
Title V and XIX Inpatient Services				1	2	
90	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in applicable column.			N	Y	90
91	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	Y	91
92	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
93	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
94	Does title V or title XIX reduce capital cost? Enter "Y" for yes or "N" for no in the applicable column.			N	N	94
95	If line 94 is "Y", enter the reduction percentage in the applicable column.					95
96	Does title V or title XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.			N	N	96
97	If line 96 is "Y", enter the reduction percentage in the applicable column.					97
Rural Providers				1	2	
105	Does this hospital qualify as a Critical Access Hospital (CAH)?			N		105
106	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)					106
107	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
108	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR §412.113(c). Enter "Y" for yes or "N" for no.			N		108

		Physical	Occupationa	Speech	Respiratory	
109	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	109

Miscellaneous Cost Reporting Information					
115	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
116	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.		N		116
117	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.		N		117
118	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
118.02			N		118.02
119	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.				119
120	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
121	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.		Y		121
Transplant Center Information					
125	Does this facility operate a transplant center? Enter "Y" for yes or "N" for no If yes, enter certification date(s) (mm/dd/yyyy) below.		N		125

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 420065	PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET S-2 PART I

126	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126
127	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
128	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
129	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
130	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
131	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
132	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
133	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
134	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134

All Providers

		1	2	
140	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 107 Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	42H055	140

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	Name: CAREALLIANCE HEALTH SERVICES		Contractor's Name: PALMETTO GBA		Contractor's Number:	141
142	Street: 315 CALHOUN ST STE 107		P.O. Box:			142
143	City: CHARLESTON	State SC	Zip Code: 29401			143

144	Are provider based physicians' costs included in Worksheet A?			N	144
145	If costs for renal services are claimed on Worksheet A, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.			Y	145
146	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.			N	146
147	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.			N	147
148	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.			N	148
149	Was the change to the simplified cost finding method? Enter "Y" for yes or "N" for no.			N	149

	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)	Part A	Part B	Title V	Title XIX	
		1	2	3	4	
155	Hospital	N	N	N	N	155
156	Subprovider - IPF	N	N	N	N	156
157	Subprovider - IRF	N	N	N	N	157
158	Subprovider - Other					158
159	SNF	N	N	N	N	159
160	HHA	N	N	N	N	160
161	CMHC		N		N	161
161.10			N		N	161.10
161.20			N		N	161.20
161.30			N		N	161.30
161.40			N		N	161.40

Multicampus

165	Is this hospital part of a multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N				165

If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip in column 3, CBSA in column 4, FTE/Campus in column 5.

	Name	County	State	Zip Code	CBSA	FTE/ Campus	
	0	1	2	3	4	5	
166							166

Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act

167	Is this provider a meaningful user under §1886 (n)? Enter "Y" for yes or "N" for no.	N		167
168	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)			168

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 420065	PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET S-2 PART I	
169	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)				169
FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4004.1)					
40-508 - 08-11				Rev. 2	

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ST. FRANCIS XAVIER BON SECOURS - CHARLESTON, SC
Cost report status - As Submitted
[Record code 1927 - 2010]

08-11	FORM CMS-2552-10		4090 (Cont.)
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 420065	PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET S-2 Part II

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

		Y/N	Date		
	Provider Organization and Operation	1	2		
1	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

		Y/N	Date	V/I	
		1	2	3	
2	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
3	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3

		Y/N	Type	Date	
	Financial Data and Reports	1	2	3	
4	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4
5	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5

		Y/N	Y/N	
	Approved Educational Activities	1	2	
6	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6
7	Are costs claimed for allied health programs? If yes, see instructions.	Y		7
8	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8
9	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N		9
10	Was an Intern-Resident program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10
11	Are GME costs directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11

		Y/N	
	Bad Debts		
12	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12
13	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
14	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14
	Bed Complement		
15	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15

		Part A		Part B		
		Y/N	Date	Y/N	Date	
	PS&R Report Data	1	2	3	4	
16	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N		16
17	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either coumn 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	04/13/2012	Y	04/13/2012	17
18	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 the cost report? If yes, see instructions.	N		N		18
19	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		N		19
20	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N		20
21	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21

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	Capital Related Cost		
22	Have assets been relifed for Medicare purposes? If yes, see instructions.		22
23	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		23
24	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions.		24
25	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		25
26	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		26
27	Has the provider's capitalization policy changed during the cost reporting period? If yes, see instructions.		27

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Interest Expense				
28	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			28
29	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions.			29
30	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			30
31	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			31
Purchased Services				
32	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			32
33	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			33
Provider-Based Physicians				
34	Are services furnished at the provider facility under an arrangement with provider-based physicians? If "Y" see instructions.			34
35	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			35
		Y/N	Date	
Home Office Costs		1	2	
36	Are home office costs claimed on the cost report?			36
37	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			37
38	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
39	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			39
40	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			40

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 420065 | PERIOD: FROM 01/01/2011 TO 12/31/2011 | WORKSHEET S-3 PART I

Component		Worksheet A Line No.	No. of Beds	Bed Days Available	CAH Hours	Inpatient Days / Outpatient Visits / Trips				Full Time Equivalents			Discharges				
						Title V	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	193	70,445			12,393	1,605	29,831					2,777	543	8,618	1
2	HMO							4,745									2
3	HMO IPF																3
4	HMO IRF																4
5	Hospital Adults & Peds. Swing Bed SNF																5
6	Hospital Adults & Peds.Swing Bed NF																6
7	Total Adults and Peds. (exclude observation beds) (see instructions)		193	70,445			12,393	1,605	29,831								7
8	Intensive Care Unit		11	4,015			1,377	150	2,561								8
9	Coronary Care Unit																9
10	Burn Intensive Care Unit																10
11	Surgical Intensive Care Unit																11
12	Other Special Care																12
13	Nursery	43 00						342	4,433								13
14	Total (see instructions)		204	74,460			13,770	2,097	36,825		874.34			2,777	543	8,618	14
15	CAH visits																15
16	Subprovider - IPF	40 00															16
17	Subprovider - IRF	41.00															17
18	Subprovider - Other	42 00															18
19	Skilled Nursing Facility	44.00															19
20	Nursing Facility	45.00															20
21	Other Long Term Care	46.00															21
22	Home Health Agency	101.00															22
23	ASC (Distinct Part)	115 00															23
24	Hospice (Distinct Part)	116 00															24
25	CMHC	99.00															25
26	RHC/FQHC (specify)	88 00															26
27	Total (sum of lines 14-26)		204								874.34						27
28	Observation Bed Days								1,202								28
28																	28.
29	Ambulance Trips																29
30	Employee discount days (see instructions)																30
31	Employee discount days -IRF																31

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA		Provider CCN: 420065	PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET S-3 PART I	
32	Labor & delivery days (see instructions)				32
33	LTCH non-covered days				33
FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4005.1)					
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HOSPITAL WAGE INDEX INFORMATION.	Provider CCN: 420065	PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET S-3 PART II

Part II - Wage Data

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (column 2 ± column 3)	Paid Hours Related to Salaries in column 4	Average Hourly Wage (column 4 ÷ column 5)	
		1	2	3	4	5	6	
SALARIES								
1	Total salaries (see instructions)	200	51,285,340	-640,284	50,645,056	1,889,048	** 26.81	1
2	Non-physician anesthetist Part A							2
3	Non-physician anesthetist Part B							3
4	Physician-Part A							4
5	Physician-Part B		578,707	-578,707				5
6	Non-physician-Part B							6
7	Interns & residents (in an approved program)	21						7
8	Home office personnel							8
9	SNF	44						9
10	Excluded area salaries (see instructions)		508,971	-33,023	475,948	25,397	** 18.74	10
OTHER WAGES AND RELATED COSTS								
11	Contract labor (see instructions)		193,063		193,063	4,901	** 39.39	11
12	Management and administrative services							12
13	Contract labor: physician-Part A		92,946		92,946	689	** 134.77	13
14	Home office salaries & wage-related costs		7,860,639		7,860,639	218,757	** 35.93	14
15	Home office: physician Part A							15
16	Teaching physician salaries (see instructions)							16
WAGE-RELATED COSTS								
17	Wage-related costs (core) Worksheet S-3, Part IV line 24		9,629,379		9,629,379			17
18	Wage-related costs (other) Worksheet S-3, Part IV line 25							18
19	Excluded areas		91,216		91,216			19
20	Non-physician anesthetist Part A							20
21	Non-physician anesthetist Part B							21
22	Physician Part A							22
23	Physician Part B		108,284		108,284			23
24	Wage-related costs (RHC/FQHC)							24
25	Interns & residents (in an approved program)							25
OVERHEAD COSTS - DIRECT SALARIES								
26	Employee Benefits	4	128	-128				26
27	Administrative & General	5	5,403,066	-569,915	4,833,151	183,469	** 26.34	27
28	Administrative & General under contract (see instructions)		15,015		15,015	770	** 19.50	28
29	Maintenance & Repairs	6						29
30	Operation of Plant	7	779,089		779,089	31,945	** 24.39	30
31	Laundry & Linen Service	8						31
32	Housekeeping	9	1,239,458		1,239,458	92,772	** 13.36	32
33	Housekeeping under contract (see instructions)							33
34	Dietary	10	1,223,861		1,223,861	82,557	** 14.82	34
35	Dietary under contract (see instructions)							35
36	Cafeteria	11						36
37	Maintenance of Personnel	12						37
38	Nursing Administration	13	736,290		736,290	19,245	** 38.26	38
39	Central Services and Supply	14						39
40	Pharmacy	15						40
41	Medical Records & Medical Records Library	16	174,129		174,129	12,297	** 14.16	41
42	Social Service	17						42
43	Other General Service	18						43

Part III - Hospital Wage Index Summary

1	Net salaries (see instructions)	50,721,648	-61,577	50,660,072	1,889,818	** 26.81	1
2	Excluded area salaries (see instructions)	508,971	-33,023	475,948	25,397	** 18.74	2
3	Subtotal salaries (line 1 minus line 2)	50,212,676	-28,554	50,184,124	1,864,421	** 26.92	3

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HOSPITAL WAGE INDEX INFORMATION		Provider CCN: 420065		PERIOD: FROM 01/01/2011 TO 12/31/2011		WORKSHEET S-3 PART II	
4	Subtotal other wages and related costs (see instructions)	8,146,648		8,146,648	224,348	** 36.31	4
5	Subtotal wage-related costs (see instructions)	9,629,379		9,629,379			5
6	Total (sum of lines 3 through 5)			67,960,152			6
7	Total overhead cost (see instructions)	9,571,036	-570,043	9,000,993	423,055	** 21.28	7
FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4005.2 - 4005.3)							
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HOSPITAL WAGE RELATED COSTS	Provider CCN: 420065	PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET S-3, PART IV

Part IV - Wage Related Cost

Part A - Core List

		Amount Reported	
RETIREMENT COST			
1	401k Employer Contributions		1
2	Tax Sheltered Annuity (TSA) Employer Contribution		2
3	Qualified and Non-Qualified Pension Plan Cost		3
4	Prior Year Pension Service Cost		4
PLAN ADMINISTRATIVE COSTS (Paid to External Organization):			
5	401k/TSA Plan Administration fees		5
6	Legal/Accounting/Management Fees-Pension Plan		6
7	Employee Managed Care Program Administration Fees		7
HEALTH AND INSURANCE COST			
8	Health Insurance (Purchased or Self Funded)	8,738,768	8
9	Prescription Drug Plan		9
10	Dental, Hearing and Vision Plan		10
11	Life Insurance (If employee is owner or beneficiary)		11
12	Accident Insurance (If employee is owner or beneficiary)		12
13	Disability Insurance (If employee is owner or beneficiary)		13
14	Long-Term Care Insurance (If employee is owner or beneficiary)		14
15	Workers' Compensation Insurance		15
16	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		16
TAXES			
17	FICA-Employers Portion Only	2,723,192	17
18	Medicare Taxes - Employers Portion Only		18
19	Unemployment Insurance		19
20	State or Federal Unemployment Taxes		20
OTHER			
21	Executive Deferred Compensation		21
22	Day Care Cost and Allowances		22
23	Tuition Reimbursement		23
24	Total Wage Related cost (Sum of lines 1 -23)	11,461,960	24

Part B - Other than Core Related Cost

25	Other Wage Related Costs (specify)_____		25

FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4005.4)

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HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provider CCN: 420065	PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET S-3, PART V

Part V - Contract Labor and Benefit Cost
Hospital and Hospital-Based Component Identification:

	Component	Contract Labor	Benefit Cost	
	0	1	2	
1	Total facility contract labor and benefit cost	301,024		1
2	Hospital	301,024		2
3	Subprovider- IPF			3
4	Subprovider- IRF			4
5	Subprovider- (Other)			5
6	Swing Beds-SNF			6
7	Swing Beds-NF			7
8	Hospital-Based SNF			8
9	Hospital-Based NF			9
10	Hospital-Based OLTC			10
11	Hospital-Based HHA			11
12	Separately Certified ASC			12
13	Hospital-Based Hospice			13
14	Hospital-Based Health Clinic RHC			14
15	Hospital-Based Health Clinic FQHC			15
16	Hospital-Based-CMHC			16
17	Renal Dialysis			17
18	Other			18

FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4005.5)

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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES			Provider CCN: 420065		PERIOD. FROM 01/01/2011 TO 12/31/2011			WORKSHEET A	
		COST CENTER DESCRIPTIONS (omit cents)	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	RECLASSIFIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	Capital Related Costs-Buildings and Fixtures		8,655,277	8,655,277	-3,644,389	5,010,888	3,808,441	8,819,329	1
2	00200	Capital Related Costs-Movable Equipment		470,499	470,499	3,644,389	4,114,888	2,140,677	6,255,565	2
3	00300	Other Capital Related Costs							-0-	3
4	00400	Employee Benefits	128	11,561,960	11,562,088		11,562,088	-591,557	10,970,531	4
5	00500	Administrative and General	5,403,066	24,108,568	29,511,632	-9,660	29,501,972	-6,136,386	23,365,588	5
6	00600	Maintenance and Repairs								6
7	00700	Operation of Plant	779,089	5,061,651	5,840,740		5,840,740		5,840,740	7
8	00800	Laundry and Linen Service		676,767	676,767		676,767		676,767	8
9	00900	Housekeeping	1,239,458	293,220	1,532,678		1,532,678		1,532,678	9
10	01000	Dietary	1,223,861	1,254,073	2,477,934		2,477,934		2,477,934	10
11	01100	Cafeteria						-989,989	-989,989	11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	736,290	102,224	838,514		838,514		838,514	13
14	01400	Central Services and Supply								14
15	01500	Pharmacy								15
16	01600	Medical Records & Medical Records Library	174,129	21,753	195,882		195,882	-449	195,433	16
17	01700	Social Service								17
18		Other General Service (specify)								18
19	01900	Nonphysician Anesthetists								19
20	02000	Nursing School								20
21	02100	Intern & Res. Service-Salary & Fringes (Approved)								21
22	02200	Intern & Res. Other Program Costs (Approved)								22
23	02300	Paramedical Ed. Program (specify)	149,830	4,804	154,634	9,660	164,294	-4,201	160,093	23
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults and Pediatrics (General Routine Care)	14,959,028	1,689,646	16,648,674	-1,842,468	14,806,206	-11,000	14,795,206	30
31	03100	Intensive Care Unit	1,951,563	316,047	2,267,610		2,267,610	-1,275	2,266,335	31
32	03200	Coronary Care Unit								32
33	03300	Burn Intensive Care Unit								33
34	03400	Surgical Intensive Care Unit								34
35		Other Special Care (specify)								35
40	04000	Subprovider - IPF								40
41	04100	Subprovider - IRF								41
42	04200	Subprovider (specify)								42

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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES					Provider CCN: 420065		PERIOD: FROM 01/01/2011 TO 12/31/2011		WORKSHEET A	
		COST CENTER DESCRIPTIONS (omit cents)	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	RECLASSIFIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
43	04300	Nursery	1,605,877	256,301	1,862,178		1,862,178		1,862,178	43
44	04400	Skilled Nursing Facility								44
45	04500	Nursing Facility								45
46	04600	Other Long Term Care								46
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	5,274,030	8,155,224	13,429,254		13,429,254	-1,595,319	11,833,935	50
51	05100	Recovery Room	654,191	45,594	699,785		699,785		699,785	51
52	05200	Labor Room and Delivery Room	79,124	8,989	88,113	1,842,468	1,930,581	-7,991	1,922,590	52
53	05300	Anesthesiology								53
54	05400	Radiology-Diagnostic	3,101,619	1,442,703	4,544,322		4,544,322	-461,023	4,083,299	54
55	05500	Radiology-Therapeutic								55
56	05600	Radioisotope								56
57	05700	Computed Tomography (CT) Scan	567,264	294,562	861,826		861,826	-3,420	858,406	57
58	05800	Magnetic Resonance Imaging (MRI)	403,527	166,776	570,303		570,303	-3,247	567,056	58
59	05900	Cardiac Catheterization	13,955	-7,696	6,259		6,259		6,259	59
60	06000	Laboratory	1,444,504	2,044,470	3,488,974		3,488,974	-262,075	3,226,899	60
60.10	06000	Oncology	540,727	157,102	697,829		697,829		697,829	60.10
60 45	06000	Vascular Lab	377,496	170,592	548,088		548,088		548,088	60.45
61	06100	PBP Clinical Laboratory Services-Program Only								61
62	06200	Whole Blood & Packed Red Blood Cells								62
63	06300	Blood Storing, Processing, & Trans.	164,538	1,282,187	1,446,725		1,446,725	-200	1,446,525	63
64	06400	Intravenous Therapy								64
65	06500	Respiratory Therapy	930,830	176,008	1,106,838		1,106,838		1,106,838	65
66	06600	Physical Therapy	1,876,175	64,930	1,941,105		1,941,105	-680	1,940,425	66
67	06700	Occupational Therapy								67
68	06800	Speech Pathology								68
69	06900	Electrocardiology	344,991	15,606	360,597		360,597	-45,245	315,352	69
70	07000	Electroencephalography								70
71	07100	Medical Supplies Charged to Patients								71
72	07200	Implantable Devices Charged to Patients		8,816,410	8,816,410		8,816,410		8,816,410	72
73	07300	Drugs Charged to Patients	2,414,293	8,433,581	10,847,874		10,847,874		10,847,874	73
74	07400	Renal Dialysis								74
75	07500	ASC (Non-Distinct Part)								75
76		Other Ancillary (specify)								76
76 30		Other Ancillary Cost Centers	399,163	15,962	415,125		415,125	-22,082	393,043	76.30
		OUTPATIENT SERVICE COST CENTERS								
88	08800	Rural Health Clinic (RHC)								88

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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES			Provider CCN: 420065		PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET A			
		COST CENTER DESCRIPTIONS (omit cents)	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	RECLASSIFIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
89	08900	Federally Qualified Health Center (FQHC)								89
90	09000	Clinic								90
91	09100	Emergency	4,117,453	798,167	4,915,620		4,915,620		4,915,620	91
92	09200	Observation Beds								92
93		Other Outpatient Service (specify)								93
		OTHER REIMBURSABLE COST CENTERS								
94	09400	Home Program Dialysis								94
95	09500	Ambulance Services								95
96	09600	Durable Medical Equipment-Rented								96
97	09700	Durable Medical Equipment-Sold								97
98		Other Reimbursable (specify)								98
99		Outpatient Rehabilitation Provider (specify)								99
100	10000	Intern-Resident Service (not appvd. tchng. prgm.)								100
101	10100	Home Health Agency								101
		SPECIAL PURPOSE COST CENTERS								
105	10500	Kidney Acquisition								105
106	10600	Heart Acquisition								106
107	10700	Liver Acquisition								107
108	10800	Lung Acquisition								108
109	10900	Pancreas Acquisition								109
110	11000	Intestinal Acquisition								110
111	11100	Islet Acquisition								111
112		Other Organ Acquisition (specify)								112
113	11300	Interest Expense							- 0 -	113
114	11400	Utilization Review-SNF							- 0 -	114
115	11500	Ambulatory Surgical Center (Distinct Part)								115
116	11600	Hospice								116
117		Other Special Purpose (specify)								117
118		SUBTOTALS (sum of lines 1-117)	50,926,200	86,553,952	137,480,160		137,480,160	-4,187,021	133,293,136	118
		NONREIMBURSABLE COST CENTERS								
190	19000	Gift, Flower, Coffee Shop, & Canteen	112,818	209,205	322,023		322,023	-322,023		190
191	19100	Research								191
192	19200	Physicians' Private Offices								192
193	19300	Nonpaid Workers								193
194		Other Nonreimbursable (specify)	246,323	101,596	347,919		347,919	-141,053	206,866	194
200		TOTAL (sum of lines 118-199)	51,285,340	86,864,760	138,150,096	- 0 -	138,150,096	-4,650,097	133,500,000	200

FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB 15-II, SECTION 4013)

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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES			Provider CCN: 420065		PERIOD: FROM 01/01/2011 TO 12/31/2011		WORKSHEET A
COST CENTER DESCRIPTIONS (omit cents)	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	RECLASSIFIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 5 ± col. 6)
	1	2	3	4	5	6	7
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RECLASSIFICATIONS	Provider CCN: 420065	PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET A-6

C - EMPLOYEE BENEFIT W2

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	INCREASES				DECREASES				Wkst. A-7 Ref.	
			COST CENTER	LINE #	SALARY	OTHER	COST CENTER	LINE #	SALARY	OTHER		
		1	2	3	4	5	6	7	8	9	10	
1	EMPLOYEE BENEFIT W2	C		4.00		128		4.00	128			1
2												2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
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21												21
22												22
23												23
24												24
25												25
26												26
27												27
28												28
29												29
500	Total reclassifications (sum of columns 4 and 5 must equal sum of columns 8 and 9)					128			128			500

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.

Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate

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RECLASSIFICATIONS	Provider CCN: 420065	PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET A-6

B - DEPRECIATION EXPENSE

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	INCREASES				DECREASES				Wkst. A-7 Ref.	
			COST CENTER	LINE #	SALARY	OTHER	COST CENTER	LINE #	SALARY	OTHER		
		1	2	3	4	5	6	7	8	9	10	
1	DEPRECIATION EXPENSE	B		2.00		3,644,389		1.00		3,644,389	9	1
2												2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
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22												22
23												23
24												24
25												25
26												26
27												27
28												28
29												29
500	Total reclassifications (sum of columns 4 and 5 must equal sum of columns 8 and 9)					3,644,389				3,644,389		500

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.

Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.

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RECLASSIFICATIONS	Provider CCN: 420065	PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET A-6

F - CPE RECLASS

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	INCREASES				DECREASES				Wkst. A-7 Ref.	
			COST CENTER	LINE #	SALARY	OTHER	COST CENTER	LINE #	SALARY	OTHER		
		1	2	3	4	5	6	7	8	9	10	
1	CPE RECLASS	F		23.00	9,660			5.00	9,660			1
2												2
3												3
4												4
5												5
6												6
7												7
8												8
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27												27
28												28
29												29
500	Total reclassifications (sum of columns 4 and 5 must equal sum of columns 8 and 9)				9,660				9,660			500

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.

Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.

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RECLASSIFICATIONS	Provider CCN: 420065	PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET A-6

A - LABOR & DELIVERY RECLA

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	INCREASES				DECREASES				Wkst. A-7 Ref.	
			COST CENTER	LINE #	SALARY	OTHER	COST CENTER	LINE #	SALARY	OTHER		
		1	2	3	4	5	6	7	8	9	10	
1	LABOR & DELIVERY RECLASS	A		52.00	1,542,569	299,899		30.00	1,542,569	299,899		1
2												2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
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23												23
24												24
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26												26
27												27
28												28
29												29
500	Total reclassifications (sum of columns 4 and 5 must equal sum of columns 8 and 9)				1,542,569	299,899			1,542,569	299,899		500

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.

Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate

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RECLASSIFICATIONS	Provider CCN: 420065	PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET A-6

E - PROFESSIONAL FEE SALARIES

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	INCREASES				DECREASES				Wkst. A-7 Ref.	
			COST CENTER	LINE #	SALARY	OTHER	COST CENTER	LINE #	SALARY	OTHER		
		1	2	3	4	5	6	7	8	9	10	
1	PROFESSIONAL FEE SALARIES	E		5.00		527,791		5.00	527,791			1
2	PROFESSIONAL FEE SALARIES	E		30.00		11,000		30.00	11,000			2
3	PROFESSIONAL FEE SALARIES	E		31.00		1,275		31.00	1,275			3
4	PROFESSIONAL FEE SALARIES	E		43.00		14,714		43.00	14,714			4
5	PROFESSIONAL FEE SALARIES	E		69.00		10,229		69.00	10,229			5
6	PROFESSIONAL FEE SALARIES	E		194.02		42,683		194.02	42,683			6
7												7
8												8
9												9
10												10
11												11
12												12
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27												27
28												28
29												29
500	Total reclassifications (sum of columns 4 and 5 must equal sum of columns 8 and 9)					607,692			607,692			500

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.

Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.

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RECLASSIFICATIONS	Provider CCN: 420065	PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET A-6

D - PATIENT TELEPHONES

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	INCREASES				DECREASES				Wkst. A-7 Ref	
			COST CENTER	LINE #	SALARY	OTHER	COST CENTER	LINE #	SALARY	OTHER		
		1	2	3	4	5	6	7	8	9	10	
1	PATIENT TELEPHONES	D		5.00		32,464		5.00	32,464			1
2												2
3												3
4												4
5												5
6												6
7												7
8												8
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28												28
29												29
500	Total reclassifications (sum of columns 4 and 5 must equal sum of columns 8 and 9)					32,464			32,464			500

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.

Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.

FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4014)

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RECONCILIATION OF CAPITAL COSTS CENTERS	Provider CCN: 420065	PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET A-7, PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES

	Description	Beginning Balances	Acquisitions			Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
			Purchases	Donation	Total				
		1	2	3	4	5	6	7	
1	Land	13,580,943					13,580,943		1
2	Land Improvements	3,222,576	18,664		18,664	6,787	3,234,453		2
3	Buildings and Fixtures	99,967,496					99,967,496		3
4	Building Improvements	17,468,462	249,979		249,979		17,718,440		4
5	Fixed Equipment	4,885,562	106,125		106,125	4,714	4,986,973		5
6	Movable Equipment	39,048,468	3,464,031		3,464,031	1,026,524	41,485,976		6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	178,173,504	3,838,799		3,838,799	1,038,025	180,974,288		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	178,173,504	3,838,799		3,838,799	1,038,025	180,974,288		10

PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 AND 2

	Description	SUMMARY OF CAPITAL							
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		9	10	11	12	13	14	15	
1	Capital Related Costs-Buildings and Fixtures	8,215,838	439,439					8,655,277	1
2	Capital Related Costs-Movable Equipment		470,499					470,499	2
3	Total (sum of lines 1-2)	8,215,838	909,938					9,125,776	3

(1) The amount in columns 9 through 14 must equal the amount on Worksheet A, column 2, lines 1 and 2. Enter in each column the appropriate amounts including any directly assigned cost that may have been included in Worksheet A, column 2, lines 1 and 2. All lines numbers are to be consistent with Worksheet A line numbers for capital cost centers.

PART III - RECONCILIATION OF CAPITAL COSTS CENTERS

	Description	COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	
		1	2	3	4	5	6	7	8	
1	Capital Related Costs-Buildings and Fixtures	134,501,328		134,501,328						1
2	Capital Related Costs-Movable Equipment	46,472,948		46,472,948						2
3	Total (sum of lines 1-2)	180,974,288		180,974,288	1.000000					3

	Description	SUMMARY OF CAPITAL							
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols 9 through 14)	
		9	10	11	12	13	14	15	
1	Capital Related Costs-Buildings and Fixtures	8,469,234	350,095					8,819,329	1
2	Capital Related Costs-Movable Equipment	5,785,066	470,499					6,255,565	2
3	Total (sum of lines 1-2)	14,254,300	820,594					15,074,894	3

(2) The amounts on lines 1 and 2 must equal the corresponding amounts on Worksheet A, column 7, lines 1 and 2. Columns 9 through 14 should include related Worksheet A-6 reclassifications, Worksheet A-8 adjustments, and Worksheet A-8-1 related organizations and home office costs. (See instructions.)

FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTIONS 4015)

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ADJUSTMENTS TO EXPENSES		Provider CCN: 420065		PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET A-8		
DESCRIPTION (1)		BASIS/CODE (2)	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		Wkst. A-7 Ref.	
				COST CENTER	LINE #		
		1	2	3	4	5	
1	Investment income - buildings and fixtures (chapter 2)			Buildings and Fixtures			1
2	Investment income - movable equipment (chapter 2)			Movable Equipment	7		2
3	Investment income - other (chapter 2)						3
4	Trade, quantity, and time discounts (chapter 8)						4
5	Refunds and rebates of expenses (chapter 8)						5
6	Rental of provider space by suppliers (chapter 8)						6
7	Telephone services (pay stations excluded) (chapter 21)						7
8	Television and radio service (chapter 21)						8
9	Parking lot (chapter 21)						9
10	Provider-based physician adjustment	Worksheet A-8-2					10
11	Sale of scrap, waste, etc. (chapter 23)						11
12	Related organization transactions (chapter 10)	Worksheet A-8-1	1,627,452				12
13	Laundry and linen service						13
14	Cafeteria-employees and guests						14
15	Rental of quarters to employee and others						15
16	Sale of medical and surgical supplies to other than patients						16
17	Sale of drugs to other than patients						17
18	Sale of medical records and abstracts						18
19	Nursing school (tuition, fees, books, etc.)						19
20	Vending machines						20
21	Income from imposition of interest, finance or penalty charges (chapter 21)						21
22	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments						22
23	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	Worksheet A-8-3		Respiratory Therapy	65		23
24	Adjustment for physical therapy costs in excess of limitation (chapter 14)	Worksheet A-8-3		Physical Therapy	66		24
25	Utilization review - physicians' compensation (chapter 21)			Utilization Review - RN?	14		25
26	Depreciation - buildings and fixtures			Buildings and Fixtures	6		26
27	Depreciation - movable equipment			Movable Equipment	7		27
28	Non-physician Anesthetist			Non-physician Anesthetist	19		28
29	Physicians' assistant						29
30	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	Worksheet A-8-3		Occupational Therapy	67		30
31	Adjustment for speech pathology costs in excess of limitation (chapter 14)	Worksheet A-8-3		Speech Pathology	68		31
32	CAH HIT Adjustment for Depreciation and Interest						32
33	Other adjustments (specify) (3)						33
33.00	OTHER INCOME	B	-88,540	ADMINISTRATIVE & GENERAL	5.00		33.00
33.02	OTHER INCOME	B	-989,989	CAFETERIA	11.00		33.02
33.03	OTHER INCOME	B	-449	MEDICAL RECORDS & LIBRARY	16.00		33.03
33.04	OTHER INCOME	B	-4,201	PARAMED ED PRGM-(SPECIFY)	23.00		33.04
33.05	OTHER INCOME	B	-7,991	DELIVERY ROOM & LABOR ROOM	52.00		33.05
33.06	OTHER INCOME	B	-7,342	RADIOLOGY-DIAGNOSTIC	54.00		33.06
33.08	OTHER INCOME	B	-680	PHYSICAL THERAPY	66.00		33.08
33.09	OTHER INCOME	B	-30,531	ELECTROCARDIOLOGY	69.00		33.09

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ADJUSTMENTS TO EXPENSES		Provider CCN: 420065		PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET A-8		
33.10	OTHER INCOME	B	-8,250	VASCULAR SERVICES	76.01		33.10
33.11	OTHER INCOME	B	-322,023	GIFT FLOWER COFFEE SHOP & CANTEEN	190.00		33.11
35.00	PHYSICIAN RECRUITMENT	A	-1,226	ADMINISTRATIVE & GENERAL	5.00		35.00
36.00	PATIENT TELEPHONES	A	-6,222	EMPLOYEE BENEFITS	4.00		36.00
36.01	PATIENT TELEPHONES	A	-42,867	ADMINISTRATIVE & GENERAL	5.00		36.01
37.00	PROF FEES - BENEFITS	A	-116,465	EMPLOYEE BENEFITS	4.00		37.00
37.01	PROF FEES - OTHER	A	-2,042,505	ADMINISTRATIVE & GENERAL	5.00		37.01
37.02	PROF FEES - A & P	A	-11,000	ADULTS & PEDIATRICS	30.00		37.02
37.03	PROF FEES - ICU	A	-1,275	INTENSIVE CARE UNIT	31.00		37.03
37.04	PROF FEES - RADIOLOGY	A	-441,513	RADIOLOGY-DIAGNOSTIC	54.00		37.04
37.05	PROF FEES - CT SCAN	A	-3,420	COMPUTED TOMOGRAPHY (CT) SCAN	57.00		37.05
37.06	PROF FEES - LAB	A	-245,593	LABORATORY	60.00		37.06
37.07	PROF FEES - EKG	A	-14,714	ELECTROCARDIOLOGY	69.00		37.07
37.08	PROF FEES - DIABETES TREATMENT	A	-10,229	DIABETES TREATMENT CENTER	76.04		37.08
37.09	PROF FEES - NON PATIENT CARE SV	A	-126,126	OTHER NON-REIMBURSABLE SERVICES	194.02		37.09
37.10	PROF FEES - A & G	A	-368	ADMINISTRATIVE & GENERAL	5.00		37.10
37.11	PROF FEES - PEDS PLUS	A	-14,927	OTHER NON-REIMBURSABLE SERVICES	194.02		37.11
38.00	STAR CONCTRACT REVENUE	A	-12,168	RADIOLOGY-DIAGNOSTIC	54.00		38.00
38.01	STAR CONTRACT REVENUE	A	-3,247	MAGNETIC RESONANCE IMAGING (MRI)	58.00		38.01
38.02	STAR CONTRACT REVENUE	A	-16,482	LABORATORY	60.00		38.02
38.03	STAR CONTRACT REVENUE	A	-200	BLOOD STORING PROCESSING & TRANS.	63.00		38.03
39.00	DEPRECIATION OFFSET	A	-3,580	CAP REL COSTS-BLDG & FIXT	1.00	9	39.00
40.00	MISC NRTPC	A	-18,763	ADMINISTRATIVE & GENERAL	5.00		40.00
41.00	ANESTHESIA & CRNA OFFSET	A	-1,595,319	OPERATING ROOM	50.00		41.00
42.00	RENT EXPENSE	A	-89,344	CAP REL COSTS-BLDG & FIXT	1.00	10	42.00
50	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200)		-4,650,097				50

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1

(2) Basis for adjustment (see instructions)
A. Costs - if cost, including applicable overhead, can be determined
B. Amount Received - if cost cannot be determined

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to Worksheet A-7.

FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4016)

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ST. FRANCIS XAVIER BON SECOURS - CHARLESTON, SC
Cost report status - As Submitted
[Record code 1927 - 2010]

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 420065	PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET A-8-1

A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount included in Wkst. A column 5	Net Adjustments (col. 4 minus col. 5) *	Wkst A-7 Ref.	
	1	2	3	4	5	6	7	
1	4.00	EMPLOYEE BENEFITS	CONTRA EMPLOYEE BENEFITS	8,269,898	8,738,768	-468,870		1
2	5.00	ADMINISTRATIVE & GENERAL	CORP ALLOCATION EXPENSE	7,114,691	17,653,236	-10,538,545		2
3	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE SALARIES	6,596,428		6,596,428		3
4	1.00	CAP REL COSTS-BLDG & FIXT	CRC-BLDG & FIX NEW	3,901,365		3,901,365	9	4
4.01	2.00	CAP REL COSTS-MVBLE EQUIP	CRC-MME NEW	36,770		36,770	9	4.01
4.02	2.00	CAP REL COSTS-MVBLE EQUIP	SHARED NEW CRC	2,103,907		2,103,907	9	4.02
4.03	60.00	LABORATORY	INTERCO LAB SVCS	308,483	308,483			4.03
4.04	76.03	PURCHASED SERVICES	PURCHASED SERVICES OTHER	1,805	5,408	-3,603		4.04
4.05	5.00	ADMINISTRATIVE & GENERAL	CONTRA SUPPORT FROM FOUND	-5,770	-5,770			4.05
4.07	30.00	ADULTS & PEDIATRICS	CONTRA SUPPORT FROM FOUND	-8,000	-8,000			4.07
4.08	43.00	NURSERY	CONTRA SUPPORT FROM FOUND	-9,545	-9,545			4.08
4.10	91.00	EMERGENCY	CONTRA SUPPORT FROM FOUND	-23,102	-23,102			4.10
5	TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			28,286,930	26,659,478	1,627,452		5

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

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

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

FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4017)

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ST. FRANCIS XAVIER BON SECOURS - CHARLESTON, SC
Cost report status - As Submitted
[Record code 1927 - 2010]

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 420065	PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET A-8-1

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

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

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

	Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office			
				Name	Percentage of Ownership	Type of Business	
	1	2	3	4	5	6	
6	B			CAREALLIANCE HEALTH SERVICES		CORPORATE OFFICE	6
7	B			ROPER HOSPITAL		SHARE STAFF AND SERVICES	7
8	B			MT PLEASANT HOSPITAL		SHARE STAFF AND SERVICES	8
9							9
10							10

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

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

FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4017)

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ST. FRANCIS XAVIER BON SECOURS - CHARLESTON, SC
Cost report status - As Submitted
[Record code 1927 - 2010]

COST ALLOCATION - GENERAL SERVICE COSTS				Provider CCN: 420065		PERIOD: FROM 01/01/2011 TO 12/31/2011						WORKSHEET B, PART I	
COST CENTER DESCRIPTIONS	NET EXPENSES FOR COST ALLOCATION (from Wkst. A col. 7)	CAPITAL RELATED COSTS BLDGS. & FIXTURES	CAPITAL RELATED COSTS MOVABLE EQUIPMENT	EMPLOYEE BENEFITS	SUBTOTAL (cols. 0-4)	ADMINIS-TRATIVE & GENERAL	MAIN-TENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	
	0	1	2	4	4A	5	6	7	8	9	10	11	
GENERAL SERVICE COST CENTERS													
1 Capital Related Costs-Buildings and Fixtures	8,819,329	8,819,329											1
2 Capital Related Costs-Movable Equipment	6,255,565		6,255,565										2
4 Employee Benefits	10,970,531	50,853		11,021,384									4
5 Administrative and General	23,365,588	623,661	150,559	1,051,790	25,191,596	25,191,596							5
6 Maintenance and Repairs													6
7 Operation of Plant	5,840,740	1,854,031	422,386	169,545	8,286,702	1,909,961		10,196,663					7
8 Laundry and Linen Service	676,767	52,234			729,001	168,024		84,665	981,690				8
9 Housekeeping	1,532,678	69,543	10,911	269,731	1,882,863	433,972		112,721		2,429,556			9
10 Dietary	2,477,954	251,965	55,066	266,337	3,051,302	703,279		408,407		99,232	4,262,220		10
11 Cafeteria	-989,989				-989,989						2,662,123	1,672,134	11
12 Maintenance of Personnel													12
13 Nursing Administration	838,514	25,005	29,482	160,231	1,053,232	242,754		40,530		9,848		21,664	13
14 Central Services and Supply													14
15 Pharmacy													15
16 Medical Records & Medical Records Library	195,433	114,669	5,113	37,894	353,109	81,386		185,866		45,160		13,842	16
17 Social Service													17
18 Other General Service (specify)													18
19 Nonphysician Anesthetists													19
20 Nursing School													20
21 Intern & Res Service-Salary & Fringes (Approved)													21
22 Intern & Res Other Program Costs (Approved)													22
23 Paramedical Education Program (specify)	160,093	12,502		34,708	207,303	47,780		20,265		4,924		10,141	23
INPATIENT ROUTINE SERVICE COST CENTERS													
30 Adults and Pediatrics (General Routine Care)	14,795,206	2,626,620	677,868	2,917,304	21,016,998	4,844,060		4,257,460	352,588	1,034,449	708,828	540,853	30
31 Intensive Care Unit	2,266,335	143,355	65,724	424,422	2,899,836	668,369		232,363	40,397	56,458	88,536	68,177	31
32 Coronary Care Unit													32
33 Burn Intensive Care Unit													33
34 Surgical Intensive Care Unit													34
35 Other Special Care Unit (specify)													35
40 Subprovider IPF													40
41 Subprovider IRF													41

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COST ALLOCATION - GENERAL SERVICE COSTS				Provider CCN: 420065		PERIOD: FROM 01/01/2011 TO 12/31/2011						WORKSHEET B, PART I	
42	Subprovider (specify)												42
43	Nursery	1,862,178	132,055	129,231	346,269	2,469,733	569,236		214,046	25,598	52,007	59,160	43
44	Skilled Nursing Facility												44
45	Nursing Facility												45
46	Other Long Term Care												46
	ANCILLARY SERVICE COST CENTERS												
50	Operating Room	11,833,935	1,020,719	1,792,580	1,147,734	15,794,968	3,640,503		1,654,473	181,677	401,993	223,268	50
51	Recovery Room	699,785	85,471	99,416	142,365	1,027,037	236,717		138,539	9,354	33,661	21,711	51
52	Labor Room and Delivery Room	1,922,590	63,637	75,777	352,913	2,414,917	556,602		103,148	47,343	25,062	57,099	52
53	Anesthesiology												53
54	Radiology-Diagnostic	4,083,299	248,258	1,077,246	674,974	6,083,777	1,402,219		402,398	104,244	97,772	127,876	54
55	Radiology-Therapeutic												55
56	Radioisotope												56
57	Computed Tomography (CT) Scan	858,406	19,712	403,645	123,448	1,405,211	323,880		31,951		7,763	23,819	57
58	Magnetic Resonance Imaging (MRI)	567,056	40,498	456,833	87,816	1,152,203	265,566		65,643		15,950	9,298	58
59	Cardiac Catheterization	6,259	21,476	75,004	3,037	105,776	24,380		34,811		8,458	422	59
60	Laboratory	3,226,899	142,793	87,326	314,353	3,771,371	869,244		231,451		56,236	68,739	60
60.10	Oncology	697,829	133,103	35,894	117,673	984,499	226,912		215,745	9,155	52,420	20,423	60.10
60.45	Vascular Lab	548,088			82,151	630,239	145,261			841		12,881	60.45
61	PBP Clinical Laboratory Services-Program Only												61
62	Whole Blood & Packed Red Blood Cells												62
63	Blood Storing, Processing, & Trans.	1,446,525	9,946	1,643	35,807	1,493,921	344,326		16,121		3,917	7,190	63
64													64
65	Respiratory Therapy	1,106,838	32,368	48,702	202,567	1,390,475	320,484		52,465	8,156	12,748	33,421	65
66	Physical Therapy	1,940,425	303,713	17,153	408,293	2,669,584	615,299		492,285	24,626	119,612	74,782	66
67	Occupational Therapy												67
68	Speech Pathology												68
69	Electrocardiology	315,352	43,336	56,503	72,851	488,042	112,486		70,244		17,067	8,993	69
70	Electroencephalography												70
71	Medical Supplies Charged to Patients												71
72	Implantable Devices Charged to Patients	8,816,410				8,816,410	2,032,050						72
73	Drugs Charged to Patients	10,847,874	115,564	144,794	525,398	11,633,630	2,681,377		187,316		45,513	58,177	73
74	Renal Dialysis												74
75	ASC (Non-Distinct Part)												75
76	Other Ancillary (specify)												76
76.30	Other Ancillary Cost Centers	393,043	53,487	129,128	86,866	662,524	152,702		86,696	21,044	21,065	16,815	76.30
	OUTPATIENT SERVICE COST CENTERS												
88	Rural Health Clinic (RHC)												88
89	Federally Qualified Health Center (FQHC)												89
90	Clinic												90

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COST ALLOCATION - GENERAL SERVICE COSTS					Provider CCN: 420065		PERIOD: FROM 01/01/2011 TO 12/31/2011						WORKSHEET B, PART I	
91	Emergency	4,915,620	465,732	199,936	896,040	6,477,328	1,492,927		754,900	156,667	183,420		175,303	91
92	Observation Beds													92
93	Other Outpatient Service (specify)													93
	OTHER REIMBURSABLE COST CENTERS													
94	Home Program Dialysis													94
95	Ambulance Services													95
96	Durable Medical Equipment-Rented													96
97	Durable Medical Equipment-Sold													97
98	Other Reimbursable (specify)													98
99	Outpatient Rehabilitation Provider (specify)													99
100	Intern-Resident Service (not appvd. tchng. prgm.)													100
101	Home Health Agency													101
	SPECIAL PURPOSE COST CENTERS													
105	Kidney Acquisition													105
106	Heart Acquisition													106
107	Liver Acquisition													107
108	Lung Acquisition													108
109	Pancreas Acquisition													109
110	Intestinal Acquisition													110
111	Islet Acquisition													111
112	Other Organ Acquisition (specify)													112
115	Ambulatory Surgical Center (Distinct Part)													115
116	Hospice													116
117	Other Special Purpose (specify)													117
118	SUBTOTALS (sum of lines 1-117)	133,293,136	8,756,306	6,247,920	10,952,517	133,153,600	25,111,756		10,094,509	981,690	2,404,735	3,459,487	1,654,054	118
	NONREIMBURSABLE COST CENTERS													
190	Gift, Flower, Coffee Shop, & Canteen		63,023	7,645	24,551	95,219	21,947		102,154		24,821	802,733	8,595	190
191	Research													191
192	Physicians' Private Offices													192
193	Nonpaid Workers													193
194	Other Nonreimbursable (specify)	206,866			44,316	251,182	57,894						9,485	194
200	Cross Foot Adjustments													200
201	Negative Cost Centers													201
202	TOTAL (sum lines 118-201)	133,500,000	8,819,329	6,255,565	11,021,384	133,500,000	25,191,596		10,196,663	981,690	2,429,556	4,262,220	1,672,134	202
FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4020)														
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COST ALLOCATION - GENERAL SERVICE COSTS				Provider CCN: 420065		PERIOD: FROM 01/01/2011 TO 12/31/2011		WORKSHEET B, PART 1	
COST CENTER DESCRIPTIONS	MAIN- TENANCE OF PERSONNEL	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE	NON- PHYSICIAN ANES- THETISTS	
	12	13	14	15	16	17	18	19	
GENERAL SERVICE COST CENTERS									
1 Capital Related Costs-Buildings and Fixtures									1
2 Capital Related Costs-Movable Equipment									2
4 Employee Benefits									4
5 Administrative and General									5
6 Maintenance and Repairs									6
7 Operation of Plant									7
8 Laundry and Linen Service									8
9 Housekeeping									9
10 Dietary									10
11 Cafeteria									11
12 Maintenance of Personnel									12
13 Nursing Administration		1,368,028							13
14 Central Services and Supply									14
15 Pharmacy									15
16 Medical Records & Medical Records Library					679,363				16
17 Social Service									17
18 Other General Service (specify)									18
19 Nonphysician Anesthetists									19
20 Nursing School									20
21 Intern & Res. Service-Salary & Fringes (Approved)									21
22 Intern & Res. Other Program Costs (Approved)									22
23 Paramedical Education Program (specify)									23
INPATIENT ROUTINE SERVICE COST CENTERS									
30 Adults and Pediatrics (General Routine Care)		638,697			169,105				30
31 Intensive Care Unit		80,511			32,196				31
32 Coronary Care Unit									32
33 Burn Intensive Care Unit									33
34 Surgical Intensive Care Unit									34
35 Other Special Care Unit (specify)									35
40 Subprovider IPF									40
41 Subprovider IRF									41
42 Subprovider (specify)									42

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COST ALLOCATION - GENERAL SERVICE COSTS				Provider CCN: 420065		PERIOD: FROM 01/01/2011 TO 12/31/2011		WORKSHEET B, PART I	
43	Nursery		69,863			21,741			43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
46	Other Long Term Care								46
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room		263,660			208,377			50
51	Recovery Room		25,639						51
52	Labor Room and Delivery Room		67,429						52
53	Anesthesiology								53
54	Radiology-Diagnostic					16,345			54
55	Radiology-Therapeutic								55
56	Radioisotope								56
57	Computed Tomography (CT) Scan								57
58	Magnetic Resonance Imaging (MRI)								58
59	Cardiac Catheterization								59
60	Laboratory								60
60.10	Oncology								60.10
61	PBP Clinical Laboratory Services-Program Only								61
62	Whole Blood & Packed Red Blood Cells								62
63	Blood Storing, Processing, & Trans.								63
64									64
65	Respiratory Therapy								65
65.									65.
60.45	Vascular Lab		15,212						60 45
61	PBP Clinical Laboratory Services-Program Only								61
62	Whole Blood & Packed Red Blood Cells								62
63	Blood Storing, Processing, & Trans.								63
64									64
65	Respiratory Therapy								65
65.									65.
66	Physical Therapy								66
67	Occupational Therapy								67
68	Speech Pathology								68
69	Electrocardiology								69
70	Electroencephalography								70
71	Medical Supplies Charged to Patients								71
72	Implantable Devices Charged to Patients								72
73	Drugs Charged to Patients								73
74	Renal Dialysis								74

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COST ALLOCATION - GENERAL SERVICE COSTS				Provider CCN: 420065		PERIOD: FROM 01/01/2011 TO 12/31/2011		WORKSHEET B, PART I	
75	ASC (Non-Distinct Part)								75
76	Other Ancillary (specify)								76
76.30	Other Ancillary Cost Centers								76.30
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic (RHC)								88
89	Federally Qualified Health Center (FQHC)								89
90	Clinic								90
91	Emergency		207,017			231,599			91
92	Observation Beds								92
93	Other Outpatient Service (specify)								93
	OTHER REIMBURSABLE COST CENTERS								
94	Home Program Dialysis								94
95	Ambulance Services								95
96	Durable Medical Equipment-Rented								96
97	Durable Medical Equipment-Sold								97
98	Other Reimbursable (specify)								98
99	Outpatient Rehabilitation Provider (specify)								99
100	Intern-Resident Service (not appvd. tchng. prgm.)								100
101	Home Health Agency								101
	SPECIAL PURPOSE COST CENTERS								
105	Kidney Acquisition								105
106	Heart Acquisition								106
107	Liver Acquisition								107
108	Lung Acquisition								108
109	Pancreas Acquisition								109
110	Intestinal Acquisition								110
111	Islet Acquisition								111
112	Other Organ Acquisition (specify)								112
115	Ambulatory Surgical Center (Distinct Part)								115
116	Hospice								116
117	Other Special Purpose (specify)								117
118	SUBTOTALS (sum of lines 1-117)		1,368,028			679,363			118
	NONREIMBURSABLE COST CENTERS								
190	Gift, Flower, Coffee Shop, & Canteen								190
191	Research								191
192	Physicians' Private Offices								192
193	Nonpaid Workers								193
194	Other Nonreimbursable (specify)								194
200	Cross Foot Adjustments								200
201	Negative Cost Centers								201

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COST ALLOCATION - GENERAL SERVICE COSTS				Provider CCN: 420065		PERIOD: FROM 01/01/2011 TO 12/31/2011		WORKSHEET B, PART 1	
202	TOTAL (sum lines 118-201)		1,368,028		679,363				202
FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4020)									
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ST. FRANCIS XAVIER BON SECOURS - CHARLESTON, SC
Cost report status - As Submitted
[Record code 1927 - 2010]

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 420065		PERIOD: FROM 01/01/2011 TO 12/31/2011		WORKSHEET B, PART I	
COST CENTER DESCRIPTIONS	NURSING SCHOOL	INTERNS & RESIDENTS SALARY AND FRINGES	INTERNS & RESIDENTS PROGRAM COSTS	PARAMEDICAL EDUCATION (SPECIFY)	SUBTOTAL	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS	TOTAL	
	20	21	22	23	24	25	26	
GENERAL SERVICE COST CENTERS								
1 Capital Related Costs-Buildings and Fixtures								1
2 Capital Related Costs-Movable Equipment								2
4 Employee Benefits								4
5 Administrative and General								5
6 Maintenance and Repairs								6
7 Operation of Plant								7
8 Laundry and Linen Service								8
9 Housekeeping								9
10 Dietary								10
11 Cafeteria								11
12 Maintenance of Personnel								12
13 Nursing Administration								13
14 Central Services and Supply								14
15 Pharmacy								15
16 Medical Records & Medical Records Library								16
17 Social Service								17
18 Other General Service (specify)								18
19 Nonphysician Anesthetists								19
20 Nursing School								20
21 Intern & Res. Service-Salary & Fringes (Approved)								21
22 Intern & Res. Other Program Costs (Approved)								22
23 Paramedical Education Program (specify)				290,413				23
INPATIENT ROUTINE SERVICE COST CENTERS								
30 Adults and Pediatrics (General Routine Care)				124,089	33,687,128		33,687,128	30
31 Intensive Care Unit				24,849	4,191,692		4,191,692	31
32 Coronary Care Unit								32
33 Burn Intensive Care Unit								33
34 Surgical Intensive Care Unit								34
35 Other Special Care Unit (specify)								35
40 Subprovider IPF								40
41 Subprovider IRF								41
42 Subprovider (specify)								42

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COST ALLOCATION - GENERAL SERVICE COSTS				Provider CCN: 420065			PERIOD: FROM 01/01/2011 TO 12/31/2011		WORKSHEET B, PART I	
43	Nursery						3,481,384		3,481,384	43
44	Skilled Nursing Facility									44
45	Nursing Facility									45
46	Other Long Term Care									46
	ANCILLARY SERVICE COST CENTERS									
50	Operating Room				103,395		22,472,314		22,472,314	50
51	Recovery Room						1,492,658		1,492,658	51
52	Labor Room and Delivery Room				3,154		3,274,754		3,274,754	52
53	Anesthesiology									53
54	Radiology-Diagnostic						8,234,631		8,234,631	54
55	Radiology-Therapeutic									55
56	Radioisotope									56
57	Computed Tomography (CT) Scan						1,792,624		1,792,624	57
58	Magnetic Resonance Imaging (MRI)						1,508,660		1,508,660	58
59	Cardiac Catheterization						173,847		173,847	59
60	Laboratory						4,997,041		4,997,041	60
60.10	Oncology						1,509,154		1,509,154	60.10
60.45	Vascular Lab						804,434		804,434	60 45
61	PBP Clinical Laboratory Services-Program Only									61
62	Whole Blood & Packed Red Blood Cells									62
63	Blood Storing, Processing, & Trans.						1,865,475		1,865,475	63
64										64
65	Respiratory Therapy						1,817,749		1,817,749	65
66	Physical Therapy						3,996,188		3,996,188	66
67	Occupational Therapy									67
68	Speech Pathology									68
69	Electrocardiology						696,832		696,832	69
70	Electroencephalography									70
71	Medical Supplies Charged to Patients									71
72	Implantable Devices Charged to Patients						10,848,460		10,848,460	72
73	Drugs Charged to Patients						14,606,013		14,606,013	73
74	Renal Dialysis									74
75	ASC (Non-Distinct Part)									75
76	Other Ancillary (specify)									76
76.30	Other Ancillary Cost Centers						960,846		960,846	76.30
	OUTPATIENT SERVICE COST CENTERS									
88	Rural Health Clinic (RHC)									88
89	Federally Qualified Health Center (FQHC)									89
90	Clinic									90
91	Emergency				34,926		9,714,087		9,714,087	91

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COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 420065		PERIOD: FROM 01/01/2011 TO 12/31/2011		WORKSHEET B, PART I	
92	Observation Beds							92
93	Other Outpatient Service (specify)							93
	OTHER REIMBURSABLE COST CENTERS							
94	Home Program Dialysis							94
95	Ambulance Services							95
96	Durable Medical Equipment-Rented							96
97	Durable Medical Equipment-Sold							97
98	Other Reimbursable (specify)							98
99	Outpatient Rehabilitation Provider (specify)							99
100	Intern-Resident Service (not apprvd. tchng. prgm.)							100
101	Home Health Agency							101
	SPECIAL PURPOSE COST CENTERS							
105	Kidney Acquisition							105
106	Heart Acquisition							106
107	Liver Acquisition							107
108	Lung Acquisition							108
109	Pancreas Acquisition							109
110	Intestinal Acquisition							110
111	Islet Acquisition							111
112	Other Organ Acquisition (specify)							112
115	Ambulatory Surgical Center (Distinct Part)							115
116	Hospice							116
117	Other Special Purpose (specify)							117
118	SUBTOTALS (sum of lines 1-117)			290,413	132,125,968		132,125,968	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop, & Canteen				1,055,469		1,055,469	190
191	Research							191
192	Physicians' Private Offices							192
193	Nonpaid Workers							193
194	Other Nonreimbursable (specify)				318,561		318,561	194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum lines 118-201)			290,413	133,500,000		133,500,000	202
FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4020)								
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[Record code 1927 - 2010]

ALLOCATION OF CAPITAL-RELATED COSTS | Provider CCN 420065 | PERIOD: FROM 01/01/2011 TO 12/31/2011 | WORKSHEET B, PART II

COST CENTER DESCRIPTIONS	DIRECTLY ASSIGNED NEW CAPITAL RELATED COSTS	CAPITAL RELATED COSTS		SUBTOTAL (sum of cols. 0-2)	EMPLOYEE BENEFITS	ADMINIS-TRATIVE & GENERAL	MAIN-TENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	
		BLDGS. & FIXTURES	MOVABLE EQUIPMENT										
	0	1	2	2A	4	5	6	7	8	9	10	11	
GENERAL SERVICE COST CENTERS													
1 Capital Related Costs-Buildings and Fixtures													1
2 Capital Related Costs-Movable Equipment													2
4		50,853		50,853	50,853								4
5 Administrative and General		623,661	150,559	774,220	4,852	779,072							5
6 Maintenance and Repairs													6
7 Operation of Plant		1,854,031	422,386	2,276,417	782	59,068		2,336,267					7
8 Laundry and Linen Service		52,234		52,234		5,196		19,399	76,829				8
9 Housekeeping		69,543	10,911	80,454	1,244	13,421		25,827		120,946			9
10 Dietary		251,965	55,066	307,031	1,229	21,750		93,574		4,940	428,524		10
11 Cafeteria											267,650	168,116	11
12 Maintenance of Personnel													12
13 Nursing Administration		25,005	29,482	54,487	739	7,507		9,286		490		2,178	13
14 Central Services and Supply													14
15 Pharmacy													15
16 Medical Records & Medical Records Library		114,669	5,113	119,782	175	2,517		42,586		2,248		1,392	16
17 Social Service													17
18 Other General Service (specify)													18
19 Nonphysician Anesthetists													19
20 Nursing School													20
21 Intern & Res. Service-Salary & Fringes (Approved)													21
22 Intern & Res. Other Program Costs (Approved)													22
23 Paramedical Education Program (specify)		12,502		12,502	160	1,478		4,643		245		1,020	23
INPATIENT ROUTINE SERVICE COST CENTERS													
30 Adults and Pediatrics (General Routine Care)		2,626,620	677,868	3,304,488	13,465	149,801		975,473	27,595	51,494	71,266	54,376	30
31 Intensive Care Unit		143,355	65,724	209,079	1,958	20,670		53,239	3,162	2,811	8,901	6,855	31
32 Coronary Care Unit													32
33 Burn Intensive Care Unit													33
34 Surgical Intensive Care Unit													34
35 Other Special Care Unit (specify)													35
40 Subprovider IPF													40
41 Subprovider IRF													41

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ALLOCATION OF CAPITAL-RELATED COSTS								Provider CCN: 420065		PERIOD: FROM 01/01/2011 TO 12/31/2011		WORKSHEET B, PART II	
42	Subprovider (specify)												42
43	Nursery		132,055	129,231	261,286	1,598	17,604		49,042	2,003	2,589		5,948	43
44	Skilled Nursing Facility													44
45	Nursing Facility													45
46	Other Long Term Care													46
	ANCILLARY SERVICE COST CENTERS													
50	Operating Room		1,020,719	1,792,580	2,813,299	5,295	112,587		379,074	14,218	20,012		22,447	50
51	Recovery Room		85,471	99,416	184,887	657	7,321		31,742	732	1,676		2,183	51
52	Labor Room and Delivery Room		63,637	75,777	139,414	1,628	17,214		23,633	3,705	1,248		5,741	52
53	Anesthesiology													53
54	Radiology-Diagnostic		248,258	1,077,246	1,325,504	3,114	43,365		92,198	8,158	4,867		12,857	54
55	Radiology-Therapeutic													55
56	Radioisotope													56
57	Computed Tomography (CT) Scan		19,712	403,645	423,357	570	10,016		7,321		386		2,395	57
58	Magnetic Resonance Imaging (MRI)		40,498	456,833	497,331	405	8,213		15,040		794		935	58
59	Cardiac Catheterization		21,476	75,004	96,480	14	754		7,976		421		42	59
60	Laboratory		142,793	87,326	230,119	1,450	26,882		53,030		2,800		6,911	60
60.10	Oncology		133,103	35,894	168,997	543	7,018		49,432	717	2,610		2,053	60.10
60.45	Vascular Lab					379	4,492			66			1,295	60.45
61	PBP Clinical Laboratory Services-Program Only													61
62	Whole Blood & Packed Red Blood Cells													62
63	Blood Storing, Processing, & Trans.		9,946	1,643	11,589	165	10,649		3,694		195		723	63
64	Intravenous Therapy													64
65	Respiratory Therapy		32,368	48,702	81,070	935	9,911		12,021	638	635		3,360	65
66	Physical Therapy		303,713	17,153	320,866	1,884	19,029		112,793	1,927	5,954		7,519	66
67	Occupational Therapy													67
68	Speech Pathology													68
69	Electrocardiology		43,336	56,503	99,839	336	3,479		16,094		850		904	69
70	Electroencephalography													70
71	Medical Supplies Charged to Patients													71
72	Implantable Devices Charged to Patients						62,843							72
73	Drugs Charged to Patients		115,564	144,794	260,358	2,424	82,925		42,918		2,266		5,849	73
74	Renal Dialysis													74
75	ASC (Non-Distinct Part)													75
76	Other Ancillary (specify)													76
76.30	Other Ancillary Cost Centers		53,487	129,128	182,615	401	4,723		19,864	1,647	1,048		1,690	76.30
	OUTPATIENT SERVICE COST CENTERS													
88	Rural Health Clinic (RHC)													88
89	Federally Qualified Health Center (FQHC)													89
90	Clinic													90

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ALLOCATION OF CAPITAL-RELATED COSTS								Provider CCN: 420065		PERIOD: FROM 01/01/2011 TO 12/31/2011		WORKSHEET B, PART II	
91	Emergency		465,732	199,936	665,668	4,134	46,170	172,963	12,261	9,131		17,625	91
92	Observation Beds												92
93	Other Outpatient Service (specify)												93
	OTHER REIMBURSABLE COST CENTERS												
94	Home Program Dialysis												94
95	Ambulance Services												95
96	Durable Medical Equipment-Rented												96
97	Durable Medical Equipment-Sold												97
98	Other Reimbursable (specify)												98
99	Outpatient Rehabilitation Provider (specify)												99
100	Intern-Resident Service (not apprvd. tchng. prgm.)												100
101	Home Health Agency												101
	SPECIAL PURPOSE COST CENTERS												
105	Kidney Acquisition												105
106	Heart Acquisition												106
107	Liver Acquisition												107
108	Lung Acquisition												108
109	Pancreas Acquisition												109
110	Intestinal Acquisition												110
111	Islet Acquisition												111
112	Other Organ Acquisition (specify)												112
115	Ambulatory Surgical Center (Distinct Part)												115
116	Hospice												116
117	Other Special Purpose (specify)												117
118	SUBTOTALS (sum of lines 1-117)		8,756,306	6,247,920	15,004,226	50,536	776,603	2,312,862	76,829	119,710	347,817	1,166,298	118
	NONREIMBURSABLE COST CENTERS												
190	Gift, Flower, Coffee Shop, & Canteen		63,023	7,645	70,668	113	679	23,405		1,236	80,707	864	190
191	Research												191
192	Physicians' Private Offices												192
193	Nonpaid Workers												193
194	Other Nonreimbursable (specify)					204	1,790					954	194
200	Cross Foot Adjustments												200
201	Negative Cost Centers											99,534	201
202	TOTAL (sum lines 118-201)		8,819,329	6,255,565	15,074,894	50,853	779,072	2,336,267	76,829	120,946	428,524	267,650	202
FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4021)													
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[Record code 1927 - 2010]

ALLOCATION OF CAPITAL-RELATED COSTS					Provider CCN: 420065		PERIOD: FROM 01/01/2011 TO 12/31/2011		WORKSHEET B, PART II	
COST CENTER DESCRIPTIONS	CAFETERIA	MAIN- TENANCE OF PERSONNEL	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE	NON- PHYSICIAN ANES- THETISTS	
	11	12	13	14	15	16	17	18	19	
GENERAL SERVICE COST CENTERS										
1 Capital Related Costs-Buildings and Fixtures										1
2 Capital Related Costs-Movable Equipment										2
4										4
5 Administrative and General										5
6 Maintenance and Repairs										6
7 Operation of Plant										7
8 Laundry and Linen Service										8
9 Housekeeping										9
10 Dietary										10
11 Cafeteria	168,116									11
12 Maintenance of Personnel										12
13 Nursing Administration	2,178		74,687							13
14 Central Services and Supply										14
15 Pharmacy										15
16 Medical Records & Medical Records Library	1,392					168,700				16
17 Social Service										17
18 Other General Service (specify)										18
19 Nonphysician Anesthetists										19
20 Nursing School										20
21 Intern & Res. Service-Salary & Fringes (Approved)										21
22 Intern & Res. Other Program Costs (Approved)										22
23 Paramedical Education Program (specify)	1,020									23
INPATIENT ROUTINE SERVICE COST CENTERS										
30 Adults and Pediatrics (General Routine Care)	54,376		34,871			41,973				30
31 Intensive Care Unit	6,855		4,395			7,991				31
32 Coronary Care Unit										32
33 Burn Intensive Care Unit										33
34 Surgical Intensive Care Unit										34
35 Other Special Care Unit (specify)										35
40 Subprovider IPF										40
41 Subprovider IRF										41
42 Subprovider (specify)										42

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ALLOCATION OF CAPITAL-RELATED COSTS						Provider CCN: 420065		PERIOD: FROM 01/01/2011 TO 12/31/2011			WORKSHEET B, PART II	
43	Nursery	5,948		3,814			5,396					43
44	Skilled Nursing Facility											44
45	Nursing Facility											45
46	Other Long Term Care											46
	ANCILLARY SERVICE COST CENTERS											
50	Operating Room	22,447		14,394			51,720					50
51	Recovery Room	2,183		1,400								51
52	Labor Room and Delivery Room	5,741		3,681								52
53	Anesthesiology											53
54	Radiology-Diagnostic	12,857					4,057					54
55	Radiology-Therapeutic											55
56	Radioisotope											56
57	Computed Tomography (CT) Scan	2,395										57
58	Magnetic Resonance Imaging (MRI)	935										58
59	Cardiac Catheterization	42										59
60	Laboratory	6,911										60
60.10	Oncology	2,053										60.10
60.45	Vascular Lab	1,295		830								60 45
61	PBP Clinical Laboratory Services-Program Only											61
62	Whole Blood & Packed Red Blood Cells											62
63	Blood Storing, Processing, & Trans.	723										63
64	Intravenous Therapy											64
65	Respiratory Therapy	3,360										65
66	Physical Therapy	7,519										66
67	Occupational Therapy											67
68	Speech Pathology											68
69	Electrocardiology	904										69
70	Electroencephalography											70
71	Medical Supplies Charged to Patients											71
72	Implantable Devices Charged to Patients											72
73	Drugs Charged to Patients	5,849										73
74	Renal Dialysis											74
75	ASC (Non-Distinct Part)											75
76	Other Ancillary (specify)											76
76.30	Other Ancillary Cost Centers	1,690										76 30
	OUTPATIENT SERVICE COST CENTERS											
88	Rural Health Clinic (RHC)											88
89	Federally Qualified Health Center (FQHC)											89
90	Clinic											90
91	Emergency	17,625		11,302			57,563					91

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ALLOCATION OF CAPITAL-RELATED COSTS					Provider CCN: 420065		PERIOD: FROM 01/01/2011 TO 12/31/2011		WORKSHEET B, PART II	
92	Observation Beds									92
93	Other Outpatient Service (specify)									93
	OTHER REIMBURSABLE COST CENTERS									
94	Home Program Dialysis									94
95	Ambulance Services									95
96	Durable Medical Equipment-Rented									96
97	Durable Medical Equipment-Sold									97
98	Other Reimbursable (specify)									98
99	Outpatient Rehabilitation Provider (specify)									99
100	Intern-Resident Service (not apprvd. tchng. prgm.)									100
101	Home Health Agency									101
	SPECIAL PURPOSE COST CENTERS									
105	Kidney Acquisition									105
106	Heart Acquisition									106
107	Liver Acquisition									107
108	Lung Acquisition									108
109	Pancreas Acquisition									109
110	Intestinal Acquisition									110
111	Islet Acquisition									111
112	Other Organ Acquisition (specify)									112
115	Ambulatory Surgical Center (Distinct Part)									115
116	Hospice									116
117	Other Special Purpose (specify)									117
118	SUBTOTALS (sum of lines 1-117)	166,298		74,687		168,700				118
	NONREIMBURSABLE COST CENTERS									
190	Gift, Flower, Coffee Shop, & Canteen	864								190
191	Research									191
192	Physicians' Private Offices									192
193	Nonpaid Workers									193
194	Other Nonreimbursable (specify)	954								194
200	Cross Foot Adjustments									200
201	Negative Cost Centers	99,534								201
202	TOTAL (sum lines 118-201)	267,650		74,687		168,700				202
FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4021)										
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ALLOCATION OF CAPITAL-RELATED COSTS			Provider CCN: 420065		PERIOD: FROM 01/01/2011 TO 12/31/2011		WORKSHEET B, PART II	
COST CENTER DESCRIPTIONS	NURSING SCHOOL	INTERNS & RESIDENTS SALARY AND FRINGES	INTERNS & RESIDENTS PROGRAM COSTS	PARAMEDICAL EDUCATION (SPECIFY)	SUBTOTAL	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS	TOTAL	
	20	21	22	23	24	25	26	
GENERAL SERVICE COST CENTERS								
1 Capital Related Costs-Buildings and Fixtures								1
2 Capital Related Costs-Movable Equipment								2
4								4
5 Administrative and General								5
6 Maintenance and Repairs								6
7 Operation of Plant								7
8 Laundry and Linen Service								8
9 Housekeeping								9
10 Dietary								10
11 Cafeteria								11
12 Maintenance of Personnel								12
13 Nursing Administration								13
14 Central Services and Supply								14
15 Pharmacy								15
16 Medical Records & Medical Records Library								16
17 Social Service								17
18 Other General Service (specify)								18
19 Nonphysician Anesthetists								19
20 Nursing School								20
21 Intern & Res. Service-Salary & Fringes (Approved)								21
22 Intern & Res. Other Program Costs (Approved)								22
23 Paramedical Education Program (specify)				20,048				23
INPATIENT ROUTINE SERVICE COST CENTERS								
30 Adults and Pediatrics (General Routine Care)					4,724,802		4,724,802	30
31 Intensive Care Unit					319,061		319,061	31
32 Coronary Care Unit								32
33 Burn Intensive Care Unit								33
34 Surgical Intensive Care Unit								34
35 Other Special Care Unit (specify)								35
40 Subprovider IPF								40
41 Subprovider IRF								41
42 Subprovider (specify)								42

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ALLOCATION OF CAPITAL-RELATED COSTS		Provider CCN: 420065	PERIOD: FROM 01/01/2011 TO 12/31/2011		WORKSHEET B, PART II	
43	Nursery		349,280		349,280	43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
46	Other Long Term Care					46
	ANCILLARY SERVICE COST CENTERS					
50	Operating Room		3,433,046		3,433,046	50
51	Recovery Room		230,598		230,598	51
52	Labor Room and Delivery Room		196,264		196,264	52
53	Anesthesiology					53
54	Radiology-Diagnostic		1,494,120		1,494,120	54
55	Radiology-Therapeutic					55
56	Radioisotope					56
57	Computed Tomography (CT) Scan		444,045		444,045	57
58	Magnetic Resonance Imaging (MRI)		522,718		522,718	58
59	Cardiac Catheterization		105,687		105,687	59
60	Laboratory		321,192		321,192	60
60.10	Oncology		231,370		231,370	60.10
60.45	Vascular Lab		7,062		7,062	60.45
61	PBP Clinical Laboratory Services-Program Only					61
62	Whole Blood & Packed Red Blood Cells					62
63	Blood Storing, Processing, & Trans.		27,015		27,015	63
64	Intravenous Therapy					64
65	Respiratory Therapy		108,570		108,570	65
66	Physical Therapy		469,972		469,972	66
67	Occupational Therapy					67
68	Speech Pathology					68
69	Electrocardiology		121,502		121,502	69
70	Electroencephalography					70
71	Medical Supplies Charged to Patients					71
72	Implantable Devices Charged to Patients		62,843		62,843	72
73	Drugs Charged to Patients		396,740		396,740	73
74	Renal Dialysis					74
75	ASC (Non-Distinct Part)					75
76	Other Ancillary (specify)					76
76.30	Other Ancillary Cost Centers		211,988		211,988	76.30
	OUTPATIENT SERVICE COST CENTERS					
88	Rural Health Clinic (RHC)					88
89	Federally Qualified Health Center (FQHC)					89
90	Clinic					90
91	Emergency		996,817		996,817	91

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ALLOCATION OF CAPITAL-RELATED COSTS			Provider CCN: 420065		PERIOD: FROM 01/01/2011 TO 12/31/2011		WORKSHEET B, PART II	
92	Observation Beds							92
93	Other Outpatient Service (specify)							93
	OTHER REIMBURSABLE COST CENTERS							
94	Home Program Dialysis							94
95	Ambulance Services							95
96	Durable Medical Equipment-Rented							96
97	Durable Medical Equipment-Sold							97
98	Other Reimbursable (specify)							98
99	Outpatient Rehabilitation Provider (specify)							99
100	Intern-Resident Service (not appvd. tchng. prgm.)							100
101	Home Health Agency							101
	SPECIAL PURPOSE COST CENTERS							
105	Kidney Acquisition							105
106	Heart Acquisition							106
107	Liver Acquisition							107
108	Lung Acquisition							108
109	Pancreas Acquisition							109
110	Intestinal Acquisition							110
111	Islet Acquisition							111
112	Other Organ Acquisition (specify)							112
115	Ambulatory Surgical Center (Distinct Part)							115
116	Hospice							116
117	Other Special Purpose (specify)							117
118	SUBTOTALS (sum of lines 1-117)					14,774,692		14,774,692 118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop, & Canteen					177,672		177,672 190
191	Research							191
192	Physicians' Private Offices							192
193	Nonpaid Workers							193
194	Other Nonreimbursable (specify)					2,948		2,948 194
200	Cross Foot Adjustments				20,048	20,048		20,048 200
201	Negative Cost Centers					99,534		99,534 201
202	TOTAL (sum lines 118-201)				20,048	15,074,894		15,074,894 202
FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4021)								
40-546 - 08-11							Rev. 2	

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COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 420065 | PERIOD: FROM 01/01/2011 TO 12/31/2011 | WORKSHEET B-1

	COST CENTER DESCRIPTIONS	CAPITAL RELATED COST BLDGS. & FIXTURES (SQUARE FEET)	CAPITAL RELATED COST MOVABLE EQUIPMENT (DOLLAR VALUE)	EMPLOYEE BENEFITS (GROSS SALARIES)	RECONCIL-IATION	ADMINIS-TRATIVE & GENERAL (ACCUM. COST)	MAIN-TENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSE-KEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	
		1	2	4	5A	5	6	7	8	9	10	11	
	GENERAL SERVICE COST CENTERS												
1	Capital Related Costs-Buildings and Fixtures	344,947											1
2	Capital Related Costs-Movable Equipment		3,616,616										2
4	Employee Benefits	1,989		50,645,056									4
5	Administrative and General	24,393	87,045	4,833,151	-25,191,596	109,298,392							5
6	Maintenance and Repairs												6
7	Operation of Plant	72,516	244,200	779,089		8,286,702		246,049					7
8	Laundry and Linen Service	2,043				729,001		2,043	901,550				8
9	Housekeeping	2,720	6,308	1,239,458		1,882,863		2,720		241,286			9
10	Dietary	9,855	31,836	1,223,861		3,051,302		9,855		9,855	530,321		10
11	Cafeteria				989,989	-1					331,231	71,396	11
12	Maintenance of Personnel												12
13	Nursing Administration	978	17,045	736,290		1,053,232		978		978		925	13
14	Central Services and Supply												14
15	Pharmacy												15
16	Medical Records & Medical Records Library	4,485	2,956	174,129		353,109		4,485		4,485		591	16
17	Social Service												17
18	Other General Service (specify)												18
19	Nonphysician Anesthetists												19
20	Nursing School												20
21	Intern & Res. Service-Salary & Fringes (Approved)												21
22	Intern & Res. Other Program Costs (Approved)												22
23	Paramedical Education Program (specify)	489		159,490		207,303		489		489		433	23
	INPATIENT ROUTINE SERVICE COST CENTERS												
30	Adults and Pediatrics (General Routine Care)	102,734	391,905	13,405,459		21,016,998		102,734	323,805	102,734	88,195	23,093	30
31	Intensive Care Unit	5,607	37,998	1,950,288		2,899,836		5,607	37,099	5,607	11,016	2,911	31
32	Coronary Care Unit												32
33	Burn Intensive Care Unit												33
34	Surgical Intensive Care Unit												34
35	Other Special Care Unit (specify)												35
40	Subprovider IPF												40
41	Subprovider IRF												41

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COST ALLOCATION - STATISTICAL BASIS							Provider CCN: 420065		PERIOD: FROM 01/01/2011 TO 12/31/2011		WORKSHEET B-1	
42	Subprovider (specify)											42
43	Nursery	5,165	74,714	1,591,163		2,469,733	5,165	23,508	5,165		2,526	43
44	Skilled Nursing Facility											44
45	Nursing Facility											45
46	Other Long Term Care											46
ANCILLARY SERVICE COST CENTERS												
50	Operating Room	39,923	1,036,367	5,274,030		15,794,968	39,923	166,846	39,923		9,533	50
51	Recovery Room	3,343	57,477	654,191		1,027,037	3,343	8,590	3,343		927	51
52	Labor Room and Delivery Room	2,489	43,810	1,621,693		2,414,917	2,489	43,478	2,489		2,438	52
53	Anesthesiology											53
54	Radiology-Diagnostic	9,710	622,803	3,101,619		6,083,777	9,710	95,734	9,710		5,460	54
55	Radiology-Therapeutic											55
56	Radioisotope											56
57	Computed Tomography (CT) Scan	771	233,365	567,264		1,405,211	771		771		1,017	57
58	Magnetic Resonance Imaging (MRI)	1,584	264,115	403,527		1,152,203	1,584		1,584		397	58
59	Cardiac Catheterization	840	43,363	13,955		105,776	840		840		18	59
60	Laboratory	5,585	50,487	1,444,504		3,771,371	5,585		5,585		2,935	60
60.10	Oncology	5,206	20,752	540,727		984,499	5,206	8,408	5,206		872	60.10
60.45	Vascular Lab			377,496		630,239		772			550	60.45
61	PBP Clinical Laboratory Services-Program Only											61
62	Whole Blood & Packed Red Blood Cells											62
63	Blood Storing, Processing, & Trans.	389	950	164,538		1,493,921	389		389		307	63
64	Intravenous Therapy											64
65	Respiratory Therapy	1,266	28,157	930,830		1,390,475	1,266	7,490	1,266		1,427	65
66	Physical Therapy	11,879	9,917	1,876,175		2,669,584	11,879	22,616	11,879		3,193	66
67	Occupational Therapy											67
68	Speech Pathology											68
69	Electrocardiology	1,695	32,667	334,762		488,042	1,695		1,695		384	69
70	Electroencephalography											70
71	Medical Supplies Charged to Patients											71
72	Implantable Devices Charged to Patients					8,816,410						72
73	Drugs Charged to Patients	4,520	83,712	2,414,293		11,633,630	4,520		4,520		2,484	73
74	Renal Dialysis											74
75	ASC (Non-Distinct Part)											75
76	Other Ancillary (specify)											76
76.30	Other Ancillary Cost Centers	2,092	74,655	399,163		662,524	2,092	19,326	2,092		718	76.30
OUTPATIENT SERVICE COST CENTERS												
88	Rural Health Clinic (RHC)											88
89	Federally Qualified Health Center (FQHC)											89
90	Clinic											90

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COST ALLOCATION - STATISTICAL BASIS							Provider CCN: 420065		PERIOD: FROM 01/01/2011 TO 12/31/2011		WORKSHEET B-1	
91	Emergency	18,216	115,592	4,117,453		6,477,328	18,216	143,878	18,216		7,485	91
92	Observation Beds											92
93	Other Outpatient Service (specify)											93
OTHER REIMBURSABLE COST CENTERS												
94	Home Program Dialysis											94
95	Ambulance Services											95
96	Durable Medical Equipment-Rented											96
97	Durable Medical Equipment-Sold											97
98	Other Reimbursable (specify)											98
99	Outpatient Rehabilitation Provider (specify)											99
100	Intern-Resident Service (not appvd. tchng. prgm.)											100
101	Home Health Agency											101
SPECIAL PURPOSE COST CENTERS												
105	Kidney Acquisition											105
106	Heart Acquisition											106
107	Liver Acquisition											107
108	Lung Acquisition											108
109	Pancreas Acquisition											109
110	Intestinal Acquisition											110
111	Islet Acquisition											111
112	Other Organ Acquisition (specify)											112
115	Ambulatory Surgical Center (Distinct Part)											115
116	Hospice											116
117	Other Special Purpose (specify)											117
118	SUBTOTALS (sum of lines 1-117)	342,482	3,612,196	50,328,600	-24,201,608	108,951,992	243,584	901,550	238,821	430,442	70,624	118
NONREIMBURSABLE COST CENTERS												
190	Gift, Flower, Coffee Shop, & Canteen	2,465	4,420	112,818		95,219	2,465		2,465	99,879	367	190
191	Research											191
192	Physicians' Private Offices											192
193	Nonpaid Workers											193
194	Other Nonreimbursable (specify)			203,640		251,182					405	194
200	Cross foot adjustments											200
201	Negative cost centers											201
202	Cost to be allocated (per Worksheet B, Part I)	8,819,329	6,255,565	11,021,384		25,191,596	10,196,663	981,690	2,429,556	4,262,220	1,672,134	202
203	Unit cost multiplier (Worksheet B, Part I)	25.57	1.73	0.217620		0.230485	41.44	1.088891	10.07	8.04	23.42	203
204	Cost to be allocated (per Worksheet B, Part II)			50,853		779,072	2,336,267	76,829	120,946	428,524	267,650	204
205	Unit cost multiplier (Worksheet B, Part II)			0.001004		0.007128	9.50	0.085219	0.501256	0.808046	2.35	205
FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4020)												
Rev. 2											40-561 - 08-11	

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COST ALLOCATION - STATISTICAL BASIS				Provider CCN: 420065		PERIOD: FROM 01/01/2011 TO 12/31/2011		WORKSHEET B-1	
COST CENTER DESCRIPTIONS	MAIN- TENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINIS-TRATION (DIRECT NURS. HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	OTHER GENERAL SERVICE (SPECIFY)	NON- PHYSICIAN ANES- THETISTS (ASGND TIME)	
	12	13	14	15	16	17	18	19	
GENERAL SERVICE COST CENTERS									
1 Capital Related Costs-Buildings and Fixtures									1
2 Capital Related Costs-Movable Equipment									2
4 Employee Benefits									4
5 Administrative and General									5
6 Maintenance and Repairs									6
7 Operation of Plant									7
8 Laundry and Linen Service									8
9 Housekeeping									9
10 Dietary									10
11 Cafeteria									11
12 Maintenance of Personnel									12
13 Nursing Administration		49,463							13
14 Central Services and Supply									14
15 Pharmacy									15
16 Medical Records & Medical Records Library					195,184,976				16
17 Social Service									17
18 Other General Service (specify)									18
19 Nonphysician Anesthetists									19
20 Nursing School									20
21 Intern & Res. Service-Salary & Fringes (Approved)									21
22 Intern & Res. Other Program Costs (Approved)									22
23 Paramedical Education Program (specify)									23
INPATIENT ROUTINE SERVICE COST CENTERS									
30 Adults and Pediatrics (General Routine Care)		23,093			48,579,400				30
31 Intensive Care Unit		2,911			9,248,932				31
32 Coronary Care Unit									32
33 Burn Intensive Care Unit									33
34 Surgical Intensive Care Unit									34
35 Other Special Care Unit (specify)									35
40 Subprovider IPF									40
41 Subprovider IRF									41
42 Subprovider (specify)									42

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COST ALLOCATION - STATISTICAL BASIS				Provider CCN: 420065		PERIOD: FROM 01/01/2011 TO 12/31/2011		WORKSHEET B-1	
43	Nursery		2,526		6,245,622				43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
46	Other Long Term Care								46
ANCILLARY SERVICE COST CENTERS									
50	Operating Room		9,533		59,861,276				50
51	Recovery Room		927						51
52	Labor Room and Delivery Room		2,438						52
53	Anesthesiology								53
54	Radiology-Diagnostic				4,695,502				54
55	Radiology-Therapeutic								55
56	Radioisotope								56
57	Computed Tomography (CT) Scan								57
58	Magnetic Resonance Imaging (MRI)								58
59	Cardiac Catheterization								59
60	Laboratory								60
60.10	Oncology								60.10
60.45	Vascular Lab		550						60.45
61	PBP Clinical Laboratory Services-Program Only								61
62	Whole Blood & Packed Red Blood Cells								62
63	Blood Storing, Processing, & Trans.								63
64	Intravenous Therapy								64
65	Respiratory Therapy								65
66	Physical Therapy								66
67	Occupational Therapy								67
68	Speech Pathology								68
69	Electrocardiology								69
70	Electroencephalography								70
71	Medical Supplies Charged to Patients								71
72	Implantable Devices Charged to Patients								72
73	Drugs Charged to Patients								73
74	Renal Dialysis								74
75	ASC (Non-Distinct Part)								75
76	Other Ancillary (specify)								76
76.30	Other Ancillary Cost Centers								76.30
OUTPATIENT SERVICE COST CENTERS									
88	Rural Health Clinic (RHC)								88
89	Federally Qualified Health Center (FQHC)								89
90	Clinic								90
91	Emergency		7,485		66,554,240				91

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COST ALLOCATION - STATISTICAL BASIS				Provider CCN: 420065		PERIOD: FROM 01/01/2011 TO 12/31/2011		WORKSHEET B-1	
92	Observation Beds								92
93	Other Outpatient Service (specify)								93
OTHER REIMBURSABLE COST CENTERS									
94	Home Program Dialysis								94
95	Ambulance Services								95
96	Durable Medical Equipment-Rented								96
97	Durable Medical Equipment-Sold								97
98	Other Reimbursable (specify)								98
99	Outpatient Rehabilitation Provider (specify)								99
100	Intern-Resident Service (not appvd. tchng. prgm.)								100
101	Home Health Agency								101
SPECIAL PURPOSE COST CENTERS									
105	Kidney Acquisition								105
106	Heart Acqnisition								106
107	Liver Acquisition								107
108	Lung Acquisition								108
109	Pancreas Acquisition								109
110	Intestinal Acquisiton								110
111	Islet Acquisition								111
112	Other Organ Acquisition (specify)								112
115	Ambulatory Surgical Center (Distinct Part)								115
116	Hospice								116
117	Other Special Purpose (specify)								117
118	SUBTOTALS (sum of lines 1-117)		49,463			195,184,976			118
NONREIMBURSABLE COST CENTERS									
190	Gift, Flower, Coffee Shop, & Canteen								190
191	Research								191
192	Physicians' Private Offices								192
193	Nonpaid Workers								193
194	Other Nonreimbursable (specify)								194
200	Cross foot adjustments								200
201	Negative cost centers								201
202	Cost to be allocated (per Worksheet B, Part I)		1,368,028			679,363			202
203	Unit cost multiplier (Worksheet B, Part I)		27.66			0.003481			203
204	Cost to be allocated (per Worksheet B, Part II)		74,687			168,700			204
205	Unit cost multiplier (Worksheet B, Part II)		1.51			0.000864			205
FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4020)									
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COST ALLOCATION - STATISTICAL BASIS	Provider CCN: 420065	PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET B-1

	COST CENTER DESCRIPTIONS	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS		PARA- MEDICAL EDUCATION (ASSIGNED TIME)	SUBTOTAL	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS	TOTAL	
			SALARY AND FRINGES (ASSIGNED TIME)	PROGRAM COSTS (ASSIGNED TIME)					
		20	21	22	23	24	25	26	
	GENERAL SERVICE COST CENTERS								
1	Capital Related Costs-Buildings and Fixtures								1
2	Capital Related Costs-Movable Equipment								2
4	Employee Benefits								4
5	Administrative and General								5
6	Maintenance and Repairs								6
7	Operation of Plant								7
8	Laundry and Linen Service								8
9	Housekeeping								9
10	Dietary								10
11	Cafeteria								11
12	Maintenance of Personnel								12
13	Nursing Administration								13
14	Central Services and Supply								14
15	Pharmacy								15
16	Medical Records & Medical Records Library								16
17	Social Service								17
18	Other General Service (specify)								18
19	Nonphysician Anesthetists								19
20	Nursing School								20
21	Intern & Res Service-Salary & Fringes (Approved)								21
22	Intern & Res. Other Program Costs (Approved)								22
23	Paramedical Education Program (specify)				3,775				23
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults and Pediatrics (General Routine Care)				1,613				30
31	Intensive Care Unit				323				31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care Unit (specify)								35
40	Subprovider IPF								40
41	Subprovider IRF								41
42	Subprovider (specify)								42

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COST ALLOCATION - STATISTICAL BASIS			Provider CCN: 420065		PERIOD: FROM 01/01/2011 TO 12/31/2011		WORKSHEET B-1	
43	Nursery							43
44	Skilled Nursing Facility							44
45	Nursing Facility							45
46	Other Long Term Care							46
ANCILLARY SERVICE COST CENTERS								
50	Operating Room			1,344				50
51	Recovery Room							51
52	Labor Room and Delivery Room			41				52
53	Anesthesiology							53
54	Radiology-Diagnostic							54
55	Radiology-Therapeutic							55
56	Radioisotope							56
57	Computed Tomography (CT) Scan							57
58	Magnetic Resonance Imaging (MRI)							58
59	Cardiac Catheterization							59
60	Laboratory							60
60.10	Oncology							60.10
60.45	Vascular Lab							60 45
61	PBP Clinical Laboratory Services-Program Only							61
62	Whole Blood & Packed Red Blood Cells							62
63	Blood Storing, Processing, & Trans.							63
64	Intravenous Therapy							64
65	Respiratory Therapy							65
66	Physical Therapy							66
67	Occupational Therapy							67
68	Speech Pathology							68
69	Electrocardiology							69
70	Electroencephalography							70
71	Medical Supplies Charged to Patients							71
72	Implantable Devices Charged to Patients							72
73	Drugs Charged to Patients							73
74	Renal Dialysis							74
75	ASC (Non-Distinct Part)							75
76	Other Ancillary (specify)							76
76.30	Other Ancillary Cost Centers							76 30
OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic (RHC)							88
89	Federally Qualified Health Center (FQHC)							89
90	Clinic							90
91	Emergency			454				91

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COST ALLOCATION - STATISTICAL BASIS			Provider CCN: 420065		PERIOD: FROM 01/01/2011 TO 12/31/2011		WORKSHEET B-1	
92	Observation Beds							92
93	Other Outpatient Service (specify)							93
OTHER REIMBURSABLE COST CENTERS								
94	Home Program Dialysis							94
95	Ambulance Services							95
96	Durable Medical Equipment-Rented							96
97	Durable Medical Equipment-Sold							97
98	Other Reimbursable (specify)							98
99	Outpatient Rehabilitation Provider (specify)							99
100	Intern-Resident Service (not appvd. tchng prgm.)							100
101	Home Health Agency							101
SPECIAL PURPOSE COST CENTERS								
105	Kidney Acquisition							105
106	Heart Acquisition							106
107	Liver Acquisition							107
108	Lung Acquisition							108
109	Pancreas Acquisition							109
110	Intestinal Acquisition							110
111	Islet Acquisition							111
112	Other Organ Acquisition (specify)							112
115	Ambulatory Surgical Center (Distinct Part)							115
116	Hospice							116
117	Other Special Purpose (specify)							117
118	SUBTOTALS (sum of lines 1-117)			3,775				118
NONREIMBURSABLE COST CENTERS								
190	Gift, Flower, Coffee Shop, & Canteen							190
191	Research							191
192	Physicians' Private Offices							192
193	Nonpaid Workers							193
194	Other Nonreimbursable (specify)							194
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (per Worksheet B, Part I)			290,413				202
203	Unit cost multiplier (Worksheet B, Part I)			76.93				203
204	Cost to be allocated (per Worksheet B, Part II)			20,048				204
205	Unit cost multiplier (Worksheet B, Part II)			5.31				205
FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4020)								
Rev. 2							40-561 - 08-11	

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Cost report status - As Submitted
[Record code 1927 - 2010]

COMPUTATION OF RATIO OF COSTS TO CHARGES					Provider CCN: 420065			PERIOD FROM 01/01/2011 TO 12/31/2011		WORKSHEET C PART I	
COST CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
			Total Costs	RCE Disallowance	Total Costs	Inpatient	Outpatient	Total (column 6 + column 7)				
	1	2	3	4	5	6	7	8	9	10	11	
INPATIENT ROUTINE SERVICE COST CENTERS												
30 Adults and Pediatrics (General Routine Care)	33,687,128		33,687,128		33,687,128	47,673,488		47,673,488				30
31 Intensive Care Unit	4,191,692		4,191,692		4,191,692	9,248,932		9,248,932				31
32 Coronary Care Unit												32
33 Burn Intensive Care Unit												33
34 Surgical Intensive Care Unit												34
35 Other Special Care (specify)												35
40 Subprovider IPF												40
41 Subprovider IRF												41
42 Subprovider (Specify)												42
43 Nursery	3,481,384		3,481,384		3,481,384	6,245,622		6,245,622				43
44 Skilled Nursing Facility												44
45 Nursing Facility												45
46 Other Long Term Care												46
ANCILLARY SERVICE COST CENTERS												
50 Operating Room	22,472,314		22,472,314		22,472,314	38,171,168	59,861,276	98,032,448	** 0.229233	** 0.229233	** 0.229233	50
51 Recovery Room	1,492,658		1,492,658		1,492,658	3,628,460	5,468,924	9,097,384	** 0.164076	** 0.164076	** 0.164076	51
52 Labor Room and Delivery Room	3,274,754		3,274,754		3,274,754	10,777,255	587,411	11,364,666	** 0.288152	** 0.288152	** 0.288152	52
53 Anesthesiology												53
54 Radiology-Diagnostic	8,234,631		8,234,631		8,234,631	6,420,293	32,846,656	39,266,948	** 0.209709	** 0.209709	** 0.209709	54
55 Radiology-Therapeutic												55
56 Radioisotope												56
57 Computed Tomography (CT) Scan	1,792,624		1,792,624		1,792,624	5,317,671	40,451,048	45,768,720	** 0.039167	** 0 039167	** 0.039167	57
58 Magnetic Resonance Imaging (MRI)	1,508,660		1,508,660		1,508,660	2,575,119	20,694,148	23,269,268	** 0.064835	** 0.064835	** 0.064835	58
59 Cardiac Catheterization	173,847		173,847		173,847	94,729		94,729	** 1.835204	** 1.835204	** 1.835204	59
60 Laboratory	4,997,041		4,997,041		4,997,041	35,177,272	32,766,544	67,943,816	** 0.073547	** 0 073547	** 0.073547	60
60.10 Oncology	1,509,154		1,509,154		1,509,154		5,148,090	5,148,090	** 0.293148	** 0.293148	** 0.293148	60.10
60.45 Vascular Lab	804,434		804,434		804,434	849,301	56,612	905,913	** 0.887982	** 0 887982	** 0.887982	60 45
61 PBP Clinical Laboratory Services-Prgm. Only												61
62 Whole Blood & Packed Red Blood Cells												62
63 Blood Storing, Processing, & Trans.	1,865,475		1,865,475		1,865,475	5,352,217	2,508,883	7,861,100	** 0.237305	** 0.237305	** 0.237305	63
64 Intravenous Therapy												64

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COMPUTATION OF RATIO OF COSTS TO CHARGES						Provider CCN: 420065			PERIOD: FROM 01/01/2011 TO 12/31/2011		WORKSHEET C PART I	
COST CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I, col 26)	Therapy Limit Adj.	Costs			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
			Total Costs	RCE Disallowance	Total Costs	Inpatient	Outpatient	Total (column 6 + column 7)				
	1	2	3	4	5	6	7	8	9	10	11	
65 Respiratory Therapy	1,817,749		1,817,749		1,817,749	4,851,823	1,392,325	6,244,148	** 0.291112	** 0.291112	** 0.291112	65
66 Physical Therapy	3,996,188		3,996,188		3,996,188	2,202,012	8,987,876	11,189,888	** 0.357125	** 0.357125	** 0.357125	66
67 Occupational Therapy												67
68 Speech Pathology												68
69 Electrocardiology	696,832		696,832		696,832	2,861,396	3,404,901	6,266,297	** 0.111203	** 0.111203	** 0.111203	69
70 Electroencephalography												70
71 Medical Supplies Charged to Patients												71
72 Implantable Devices Charged to Patients	10,848,460		10,848,460		10,848,460	20,081,368	4,041,311	24,122,680	** 0.449720	** 0.449720	** 0.449720	72
73 Drugs Charged to Patients	14,606,013		14,606,013		14,606,013	28,089,738	37,066,160	65,155,900	** 0.224170	** 0.224170	** 0.224170	73
74 Renal Dialysis												74
75 ASC (Non-Distinct Part)												75
76 Other Ancillary (specify)												76
76.30 Other Ancillary Cost Centers	960,846		960,846		960,846	1,283,830	4,051,080	5,334,910	** 0.180105	** 0.180105	** 0.180105	76 30
OUTPATIENT SERVICE COST CENTERS												
88 Rural Health Clinic (RHC)												88
89 Federally Qualified Health Center (FQHC)												89
90 Clinic												90
91 Emergency	9,714,087		9,714,087		9,714,087	15,135,965	66,554,240	81,690,208	** 0.118914	** 0.118914	** 0.118914	91
92 Observation Beds (see instructions)	1,304,807		1,304,807		1,304,807		1,559,793	1,559,793	** 0.836526	** 0.836526	** 0.836526	92
93 Other Outpatient Service (specify)												93
OTHER REIMBURSABLE COST CENTERS												
94 Home Program Dialysis												94
95 Ambulance Services												95
96 Durable Medical Equipment-Rented												96
97 Durable Medical Equipment-Sold												97
98 Other Reimbursable (specify)												98
99 Outpatient Rehabilitation Provider (specify)												99
100 Intern-Resident Service (not apprvd. tchng. prgm.)												100
101 Home Health Agency												101
SPECIAL PURPOSE COST CENTERS												
105 Kidney Acquisition												105
106 Heart Acquisition												106
107 Liver Acquisition												107
108 Lung Acquisition												108
109 Pancreas Acquisition												109

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COMPUTATION OF RATIO OF COSTS TO CHARGES						Provider CCN: 420065			PERIOD: FROM 01/01/2011 TO 12/31/2011		WORKSHEET C PART I	
COST CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I, col 26)	Therapy Limit Adj.	Costs			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
			Total Costs	RCE Dis-allowance	Total Costs	Inpatient	Outpatient	Total (column 6 + column 7)				
	1	2	3	4	5	6	7	8	9	10	11	
110 Intestinal Acquisition												110
111 Islet Acquisition												111
112 Other Organ Acquisition (specify)												112
115 Ambulatory Surgical Center (Distinct Part)												115
116 Hospice												116
117 Other Special Purpose (specify)												117
200 Subtotal (see instructions)	133,430,776		133,430,776		133,430,776	246,037,664	327,447,296	573,484,928				200
201 Less Observation Beds	1,304,807		1,304,807		1,304,807							201
202 Total (see instructions)	132,125,968		132,125,968		132,125,968	246,037,664	327,447,296	573,484,928				202
FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTIONS 4023)												
40-564 - 08-11											Rev. 2	

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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS	Provider CCN: 420065	PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET D, PART I

Medicare - Title XVIII - Hospital

		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTNE SERVICE COST CENTERS								
30	Adults & Pediatrics (General Routine Care)	4,724,802		4,724,802	31,033	152.25	12,393	1,886,834	30
31	Intensive Care Unit	319,061		319,061	2,561	124.58	1,377	171,547	31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care Unit (specify)								35
40	Subprovider IPF								40
41	Subprovider IRF								41
42	Subprovider (Other)								42
43	Nursery	349,280		349,280	4,433	78.79			43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	5,393,143		5,393,143	38,027		13,770	2,058,381	200

(A) Worksheet A line numbers

FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTIONS 4024 - 4024.1)

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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 420065	PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET D, PART II

Medicare -Title XVIII - Hospital

		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)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	3,433,046	98,032,448	** 0.035019	12,872,351	450,777	50
51	Recovery Room	230,598	9,097,384	** 0.025348	1,190,155	30,168	51
52	Labor Room and Delivery Room	196,264	11,364,666	** 0.017270			52
53	Anesthesiology						53
54	Radiology-Diagnostic	1,494,120	39,266,948	** 0.038050	4,167,643	158,579	54
55	Radiology-Therapeutic						55
56	Radioisotope						56
57	Computed Tomography (CT) Scan	444,045	45,768,720	** 0.009702	4,895,983	47,501	57
58	Magnetic Resonance Imaging (MRI)	522,718	23,269,268	** 0.022464	1,273,140	28,600	58
59	Cardiac Catheterization	105,687	94,729	** 1.115677	68,094	75,971	60
60	Laboratory	321,192	67,943,816	** 0.004727	17,969,276	84,941	60
60.10		231,370	5,148,090	** 0.044943			60.10
60.45		7,062	905,913	** 0.007795	498,012	3,882	60.45
61	PBP Clinical Laboratory Services-Prgm. Only						61
62	Whole Blood & Packed Red Blood Cells						62
63	Blood Storing, Processing, & Transfusing	27,015	7,861,100	** 0.003437	2,163,886	7,437	63
64	Intravenous Therapy						64
65	Respiratory Therapy	108,570	6,244,148	** 0.017387	2,875,763	50,001	65
66	Physical Therapy	469,972	11,189,888	** 0.042000	1,305,484	54,830	66
67	Occupational Therapy						67
68	Speech Pathology						68
69	Electrocardiology	121,502	6,266,297	** 0.019390	1,730,441	33,553	69
70	Electroencephalography						70
71	Medical Supplies Charged to Patients						71
72	Implantable Devices Charged to Patients	62,843	24,122,680	** 0.002605	7,023,857	18,297	72
73	Drugs Charged to Patients	396,740	65,155,900	** 0.006089	12,558,689	76,470	73
74	Renal Dialysis						74
75	ASC (Non-Distinct Part)						75
76	Other Ancillary (specify)						76
76.30		211,988	5,334,910	** 0.039736	814,045	21,631	76.30
88	Rural Health Clinic (RHC)						88
89	Federally Qualified Health Center (FQHC)						89
90	Clinic						90
91	Emergency	996,817	81,690,208	** 0.012202	7,166,990	87,452	91
92	Observation Beds	183,006	1,559,793	** 0.117327			92
93	Other Outpatient Service (specify)						93
	OTHER REIMBURSABLE COST CENTERS						
94	Home Program Dialysis						94
95	Ambulance Services						95
96	Durable Medical Equipment-Rented						96
97	Durable Medical Equipment-Sold						97
98	Other Reimbursable (specify)						98
200	Total (sum of lines 50 through 199)	9,564,555	510,316,896	** 0.018742	78,573,808	1,230,090	200

(A) Worksheet A line numbers

FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4024.2)

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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 420065	PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET D, PART III

Medicare -Title XVIII - Hospital

		Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	1	2	3	4	5	6	7	8	9	
INPATIENT ROUTINE SERVICE COST CENTERS											
30	Adults & Pediatrics (General Routine Care)		124,089			124,089	31,033	4.00	12,393	49,572	30
31	Intensive Care Unit		24,849			24,849	2,561	9.70	1,377	13,357	31
32	Coronary Care Unit										32
33	Burn Intensive Care Unit										33
34	Surgical Intensive Care Unit										34
35	Other Special Care Unit (specify)										35
40	Subprovider IPF										40
41	Subprovider IRF										41
42	Subprovider (Other)										42
43	Nursery						4,433				43
44	Skilled Nursing Facility										44
45	Nursing Facility										45
200	Total (sum of lines 30-199)		148,938			148,938	38,027		13,770	62,929	200

(A) Worksheet A line numbers

FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4024.3)

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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 420065	PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET D, PART IV

Medicare -Title XVIII - Hospital

		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total cost (sum of col 1 through col. 4)	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	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	1	2	3	4	5	6	7	8	9	10	11	12	13	
ANCILLARY SERVICE COST CENTERS															
50	Operating Room			103,395		103,395	103,395	98,032,448			12,872,351	13,580	17,357,446	18,312	50
51	Recovery Room							9,097,384			1,190,155		1,217,299		51
52	Labor room and Delivery Room			3,154		3,154	3,154	11,364,666							52
53	Anesthesiology														53
54	Radiology-Diagnostic							39,266,948			4,167,643		9,980,422		54
55	Radiology-Therapeutic														55
56	Radioisotope														56
57	Computed Tomography (CT) Scan							45,768,720			4,895,983		11,507,290		57
58	Magnetic Resonance Imaging (MRI)							23,269,268			1,273,140		6,321,751		58
59	Cardiac Catheterization							94,729			68,094				59
60	Laboratory							67,943,816			17,969,276		8,554,245		60
60.10	Oncology							5,148,090					1,905,379		60.10
60.45	Vascular Lab							905,913			498,012		16,925		60.45
61	PBP Clinical Laboratory Services-Prgm. Only														61
62	Whole Blood & Packed Red Blood Cells														62
63	Blood Storing, Processing, & Transfusing							7,861,100			2,163,886		1,164,615		63
64	Intravenous Therapy														64
65	Respiratory Therapy							6,244,148			2,875,763		391,902		65
66	Physical Therapy							11,189,888			1,305,484		2,849,305		66
67	Occupational Therapy														67
68	Speech Pathology														68
69	Electrocardiology							6,266,297			1,730,441		1,310,165		69
70	Electroencephalography														70
71	Medical Supplies Charged To Patients														71
72	Implantable Devices Charged to Patients							24,122,680			7,023,857		1,777,387		72
73	Drugs Charged to Patients							65,155,900			12,558,689		12,276,521		73
74	Renal Dialysis														74
75	ASC (Non-Distinct Part)														75
76	Other Ancillary (specify)														76
76.30	Other Ancillary Cost Centers							5,334,910			814,045		1,852,482		76.30

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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS									Provider CCN: 420065		PERIOD: FROM 01/01/2011 TO 12/31/2011		WORKSHEET D, PART IV	
Medicare -Title XVIII - Hospital														
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part 1, col. 8)	Ratio of Cost to Charges (col. 5 + col. 7)	Outpatient Ratio of Cost to Charges (col. 6 + col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	1	2	3	4	5	6	7	8	9	10	11	12	13	
OUTPATIENT SERVICE COST CENTERS															
88	Rural Health Clinic (RHC)														88
89	Federally Qualified Health Center (FQHC)														89
90	Clinic														90
91	Emergency			34,926		34,926	34,926	81,690,208			7,166,990	3,067	13,161,778	5,633	91
92	Observation Beds			4,807		4,807	4,807	1,559,793					627,047	1,933	92
93	Other Outpatient Service (specify)														93
OTHER REIMBURSABLE COST CENTERS															
94	Home Program Dialysis														94
95	Ambulance Services														95
96	Durable Medical Equipment-Rented														96
97	Durable Medical Equipment-Sold														97
98	Other Reimbursable (specify)														98
200	Total (sum of lines 50 through 199)			146,282		146,282	146,282	510,316,896			78,573,808	16,647	92,271,960	25,878	200
(A) Worksheet A line numbers															
FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4024.4)															
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS	Provider CCN: 420065	PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET D, PART V

Medicare -Title XVIII - Hospital

PART V - APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

		Cost to Charge Ratio from Worksheet C, Part I, col. 9	Program Charges			Program Cost			
			PPS Reimbursed Services (see instructions)	Cost Reimbursed Services Subject to Ded. & Coins (see instructions)	Cost Reimbursed Services Not Subject to Ded. & Coins. (see instructions)	PPS Services (see instructions)	Cost Services Subject to Ded. & Coins. (see instructions)	Cost Services Not Subject to Ded. & Coins. (see instructions)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
ANCILLARY SERVICE COST CENTERS									
50	Operating Room		17,357,446			3,978,899			50
51	Recovery Room		1,217,299			199,730			51
52	Labor & Delivery Room								52
53	Anesthesiology								53
54	Radiology-Diagnostic		9,980,422			2,092,984			54
55	Radiology-Therapeutic								55
56	Radioisotope								56
57	Computed Tomography (CT) Scan		11,507,290			450,706			57
58	Magnetic Resonance Imaging (MRI)		6,321,751			409,871			58
59	Cardiac Catheterization								59
60	Laboratory		8,554,245			629,139			60
60.10	Oncology		1,905,379			558,558			60.10
60.45	Vascular Lab		16,925			15,029			60.45
61	PBP Clinic Laboratory Services-Prgm. Only								61
62	Whole Blood & Packed Red Blood Cells								62
63	Blood Storing, Processing, & Transfusing		1,164,615			276,369			63
64	Intravenous Therapy								64
65	Respiratory Therapy		391,902			114,087			65
66	Physical Therapy		2,849,305			1,017,558			66
67	Occupational Therapy								67
68	Speech Pathology								68
69	Electrocardiology		1,310,165			145,694			69
70	Electroencephalography								70
71	Medical Supplies Charged To Patients								71
72	Implantable Devices Charged to Patients		1,777,387			799,326			72
73	Drugs Charged to Patients		12,276,521			2,752,028			73
74	Renal Dialysis								74
75	ASC (Non-Distinct Part)								75
76	Other Ancillary (specify)								76
76.30	Other Ancillary Cost Centers		1,852,482			316,974			76.30
OUTPATIENT SERVICE COST CENTERS									
88	Rural Health Clinic (RHC)								88
89	Federally Qualified Health Center (FQHC)								89
90	Clinic								90
91	Emergency		13,161,778			1,565,120			91
92	Observation Bed		627,047			524,541			92
93	Other Outpatient Service (specify)								93
OTHER REIMBURSABLE COST CENTERS									
94	Home Program Dialysis								94
95	Ambulance								95
96	Durable Medical Equipment-Rented								96
97	Durable Medical Equipment-Sold								97
98	Other Reimbursable Cost Center								98
200	Subtotal (see instructions)		92,271,960			15,846,613			200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		92,271,960			15,846,613			202

FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTIONS 4024.5)

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COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 420065	PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET D-1, PART I

Medicare -Title XVIII - Hospital

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	Inpatient days (including private room days and swing-bed days, excluding newborn)	31,033	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	31,033	2
3	Private room days (excluding swing-bed and observation bed days)		3
4	Semi-private room days (excluding swing-bed and observation bed days)	31,033	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	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)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	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)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	12,393	9
10	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).		10
11	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)		11
12	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.		12
13	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)		13
14	Medically necessary private room days applicable to the Program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16
	SWING BED ADJUSTMENT		
17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	33,687,128	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	33,687,128	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	General inpatient routine service charges (excluding swing-bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	33,687,128	37

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COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 420065	PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET D-1, PART II

Medicare -Title XVIII - Hospital

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS					1	
38	Adjusted general inpatient routine service cost per diem (see instructions)				1,085	38
39	Program general inpatient routine service cost (line 9 x line 38)				13,452,973	39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)					40
41	Total Program general inpatient routine service cost (line 39 + line 40)				13,452,973	41
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1	2	3	4	5	
42	Nursery (title V & XIX only) Intensive Care Type Inpatient Hospital Units						42
43	Intensive Care Unit	4,191,692	2,561	** 1,636.74	1,377	2,253,791	43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care Unit (specify)						47
						1	
48	Program inpatient ancillary service cost (Worksheet D-3, column 3, line 200)					15,111,561	48
49	Total Program inpatient costs (sum of lines 41 through 48) (see instructions)					30,818,324	49
PASS-THROUGH COST ADJUSTMENTS							
50	Pass through costs applicable to Program inpatient routine services (from Worksheet D, sum of Parts I and III)					2,121,310	50
51	Pass through costs applicable to Program inpatient ancillary services (from Worksheet D, sum of Parts II and IV)					1,246,737	51
52	Total Program excludable cost (sum of lines 50 and 51)					3,368,047	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist, and medical education costs (line 49 minus line 52)					27,450,278	53
TARGET AMOUNT AND LIMIT COMPUTATION							
54	Program discharges						54
55	Target amount per discharge						55
56	Target amount (line 54 x line 55)						56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57
58	Bonus payment (see instructions)						58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket						59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket						60
61	If line 53 ÷ line 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)						61
62	Relief payment (see instructions)						62
63	Allowable Inpatient cost plus incentive payment (see instructions)						63
PROGRAM INPATIENT ROUTINE SWING BED COST							
64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (see instructions) (title XVIII only)						64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (see instructions) (title XVIII only)						65
66	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (Title XVIII only. For CAH, see instructions.)						66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69

FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4025.2)

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COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 420065	PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET D-1, PARTS III & IV

Medicare -Title XVIII - Hospital

PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY. AND ICT/MR ONLY

70	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)		70
71	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71
72	Program routine service cost (line 9 x line 71)		72
73	Medically necessary private room cost applicable to Program (line 14 x line 35)		73
74	Total Program general inpatient routine service costs (line 72 + line 73)		74
75	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Parts II, column 26, line 45)		75
76	Per diem capital-related costs (line 75 ÷ line 2)		76
77	Program capital-related costs (line 9 x line 76)		77
78	Inpatient routine service cost (line 74 minus line 77)		78
79	Aggregate charges to beneficiaries for excess costs (from provider records)		79
80	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80
81	Inpatient routine service cost per diem limitation		81
82	Inpatient routine service cost limitation (line 9 x line 81)		82
83	Reasonable inpatient routine service costs (see instructions)		83
84	Program inpatient ancillary services (see instructions)		84
85	Utilization review - physician compensation (see instructions)		85
86	Total Program inpatient operating costs (sum of lines 83 through 85)		86

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)	1,202	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,085.53	88
89	Observation bed cost (line 87 x line 88) (see instructions)	1,304,807	89

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

		Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass-Through Cost (col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost	4,724,802	33,687,128	0.140255	1,304,807	183,006	90
91	Nursing School cost		33,687,128		1,304,807		91
92	Allied Health cost	124,089	33,687,128	0.003684	1,304,807	4,807	92
93	All other Medical Education		33,687,128		1,304,807		93

FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTIONS 4025.3 - 4025.4)

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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 420065	PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET D-3

Medicare -Title XVIII - Hospital

	(A) COST CENTER DESCRIPTION	Ratio of Cost to Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults and Pediatrics (General Routine Care)		20,302,552		30
31	Intensive Care Unit		4,964,614		31
32	Coronary Care Unit				32
33	Burn Intensive Care Unit				33
34	Surgical Intensive Care Unit				34
35	Other Special Care (specify)				35
40	Subprovider IPF				40
41	Subprovider IRF				41
42	Subprovider (Specify)				42
43	Nursery				43
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room		12,872,351	2,950,768	50
51	Recovery Room		1,190,155	195,276	51
52	Labor Room and Delivery Room				52
53	Anesthesiology				53
54	Radiology-Diagnostic		4,167,643	873,992	54
55	Radiology-Therapeutic				55
56	Radioisotope				56
57	Computed Tomography (CT) Scan		4,895,983	191,761	57
58	Magnetic Resonance Imaging (MRI)		1,275,140	82,544	58
59	Cardiac Catheterization		68,094	124,966	59
60	Laboratory		17,969,276	1,321,586	60
61	PBP Clinical Laboratory Services-Prgm. Only				61
62	Whole Blood & Packed Red Blood Cells				62
63	Blood Storing, Processing, & Trans.		2,163,886	513,501	63
64	Intravenous Therapy				64
65	Respiratory Therapy		2,875,763	837,169	65
66	Physical Therapy		1,305,484	466,221	66
67	Occupational Therapy				67
68	Speech Pathology				68
69	Electrocardiology		1,730,441	192,430	69
70	Electroencephalography				70
71	Medical Supplies Charged to Patients				71
72	Implantable Devices Charged to Patients		7,023,857	3,158,769	72
73	Drugs Charged to Patients		12,558,689	2,815,281	73
74	Renal Dialysis				74
75	ASC (Non-Distinct Part)				75
76	Other Ancillary (specify)		1,312,057	535,042	76
	OUTPATIENT SERVICE COST CENTERS				
88	Rural Health Clinic (RHC)				88
89	Federally Qualified Health Center (FQHC)				89
90	Clinic				90
91	Emergency		7,166,990	852,255	91
92	Observation Beds (see instructions)				92
93	Other Outpatient Service (specify)				93
	OTHER REIMBURSABLE COST CENTERS				
94	Home Program Dialysis				94
95	Ambulance Services				95
96	Durable Medical Equipment-Rented				96
97	Durable Medical Equipment-Sold				97
98	Other Reimbursable (specify)				98
200	Total (sum of lines 50-94 and 96-98)		78,573,808	15,111,561	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		78,573,808		202

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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 420065	PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET D-3
(A) Worksheet A line numbers			
FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4027)			
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CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 420065	PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET E, PART A	
Medicare -Title XVIII - Hospital				
PART A - INPATIENT HOSPITAL SERVICES UNDER PPS				
1	DRG amounts other than outlier payments		22,413,480	1
2	Outlier payments for discharges (see instructions)		692,390	2
3	Managed care simulated payments			3
4	Bed days available divided by number of days in the cost reporting period (see instructions) Indirect Medical Education Adjustment Calculation for Hospitals		200.71	4
5	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996 (see instructions)			5
6	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in in accordance with 42 CFR 413.79(e)			6
7	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)			7
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.			7.01
8	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 Federal Register, page 50069, August 1, 2002.			8
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.			8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)			8.02
9	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line 8 plus lines (8.01 and 8.02) (see instructions)			9
10	FTE count for allopathic and osteopathic programs in the current year from your records			10
11	FTE count for residents in dental and podiatric programs			11
12	Current year allowable FTE (see instructions)			12
13	Total allowable FTE count for the prior year			13
14	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.			14
15	Sum of lines 12 through 14 divided by 3			15
16	Adjustment for residents in initial years of the program			16
17	Adjustment for residents displaced by program or hospital closure			17
18	Adjusted rolling average FTE count			18
19	Current year resident to bed ratio (line 18 divided by line 4)			19
20	Prior year resident to bed ratio (see instructions)			20
21	Enter the lesser of lines 19 or 20 (see instructions)			21
22	IME payment adjustment (see instructions)			22
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).			23
24	IME FTE resident count over cap (see instructions)			24
25	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)			25
26	Resident to bed ratio (divide line 25 by line 4)			26
27	IME payments adjustment (see instructions)			27
28	IME Adjustment (see instructions)			28
29	Total IME payment (sum of lines 22 and 28)			29
Disproportionate Share Adjustment				
30	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		0.074200	30
31	Percentage of Medicaid patient days to total days reported on Worksheet S-2, Part I, line 24. (see instructions)		0.185800	31
32	Sum of lines 30 and 31		0.260000	32
33	Allowable disproportionate share percentage (see instructions)		0.106700	33
34	Disproportionate share adjustment (see instructions)		2,391,518	34
Additional payment for high percentage of ESRD beneficiary discharges				
40	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)			40
41	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685 (see instructions)			41
42	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)			42
43	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685 (see instructions)			43
44	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)			44
45	Average weekly cost for dialysis treatments (see instructions)			45
46	Total additional payment (line 45 times line 44 times line 41)			46
47	Subtotal (see instructions)		25,497,388	47
48	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only (see instructions)			48
49	Total payment for inpatient operating costs SCH and MDH only (see instructions)		25,497,388	49

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CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 420065	PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET E, PART A	
Medicare -Title XVIII - Hospital				
50	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)	1,980,833		50
51	Exception payment for inpatient program capital (Worksheet L, Part III) (see instructions)			51
52	Direct graduate medical education payment (from Worksheet E-4, line 49) (see instructions).			52
53	Nursing and allied health managed care payment			53
54	Special add-on payments for new technologies			54
55	Net organ acquisition cost (Worksheet D-4 Part III, col. 1, line 69)			55
56	Cost of teaching physicians (Worksheet D-5, Part II, col. 3, line 20)			56
57	Routine service other pass through costs	62,929		57
58	Ancillary service other pass through costs Worksheet D, Part IV, col. 11 line 200)	16,647		58
59	Total (sum of amounts on lines 49 through 58)	27,557,796		59
60	Primary payer payments	27,070		60
61	Total amount payable for program beneficiaries (line 59 minus line 60)	27,530,728		61
62	Deductibles billed to program beneficiaries	2,307,060		62
63	Coinsurance billed to program beneficiaries	108,389		63
64	Allowable bad debts (see instructions)	139,647		64
65	Adjusted reimbursable bad debts (see instructions)	97,753		65
66	Allowable bad debts for dual eligible beneficiaries (see instructions)	81,429		66
67	Subtotal (line 61 plus line 65 minus lines 62 and 63)	25,213,032		67
68	Credits received from manufacturers for replaced devices applicable to MS-DRG (see instructions)			68
69	Outlier payments reconciliation			69
70	Other adjustments (specify) (see instructions)			70
71	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)	25,213,032		71
72	Interim payments	25,923,756		72
73	Tentative settlement (for contractor use only)			73
74	Balance due provider (Program) (lines 71 minus the sum of lines 72 and 73)	-710,726		74
75	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			75
TO BE COMPLETED BY CONTRACTOR				
90	Operating outlier amount from Worksheet E, Part A line 2	692,390		90
91	Capital outlier from Worksheet L, Part I, line 2	73,693		91
92	Operating outlier reconciliation adjustment amount (see instructions)			92
93	Capital outlier reconciliation adjustment amount (see instructions)			93
94	The rate used to calculate the Time Value of Money (see instructions)			94
95	Time Value of Money for operating expenses (see instructions)			95
96	Time Value of Money for capital related expenses (see instructions)			96
08-11				

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ST. FRANCIS XAVIER BON SECOURS - CHARLESTON, SC
Cost report status - As Submitted
[Record code 1927 - 2010]

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 420065	PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET E, PART B	
Medicare -Title XVIII - Hospital				
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1	Medical and other services (see instructions)			1
2	Medical and other services reimbursed under OPPS (see instructions).		15,820,735	2
3	PPS payments		16,206,777	3
4	Outlier payment (see instructions)			4
5	Enter the hospital specific payment to cost ratio (see instructions)			5
6	Line 2 times line 5			6
7	Sum of lines line 3 plus line 4 divided by line 6			7
8	Transitional corridor payment (see instructions)			8
9	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200		25,878	9
10	Organ acquisition			10
11	Total cost (sum of lines 1 and 10) (see instructions)			11
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable charges			
12	Ancillary service charges			12
13	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)			13
14	Total reasonable charges (sum of lines 12 and 13)			14
	Customary charges			
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis			15
16	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)			16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)			17
18	Total customary charges (see instructions)			18
19	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			20
21	Lesser of cost or charges (line 11 minus line 20) (for CAH, see instructions)			21
22	Interns and residents (see instructions)			22
23	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, §2148)			23
24	Total prospective payment (sum of lines 3, 4, 8 and 9)		16,232,655	24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
25	Deductibles and coinsurance (see instructions)			25
26	Deductibles and Coinsurance relating to amount on line 24 (see instructions)		3,540,514	26
27	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (see instructions)		12,692,141	27
28	Direct graduate medical education payments (from Worksheet E-4, line 50)			28
29	ESRD direct medical education costs (from Worksheet E-4, line 36)			29
30	Subtotal (sum of lines 27 through 29)		12,692,141	30
31	Primary payer payments		6,240	31
32	Subtotal (line 30 minus line 31)		12,685,901	32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)			
33	Composite rate ESRD (from Worksheet I-5, line 11)			33
34	Allowable bad debts (see instructions)		336,364	34
35	Adjusted reimbursable bad debts (see instructions)		235,455	35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)		304,108	36
37	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)		12,921,356	37
38	MSP-LCC reconciliation amount from PS&R			38
39	Other adjustments (specify) (see instructions)			39
40	Subtotal (line 37 plus or minus lines 39 minus 38)		12,921,356	40
41	Interim payments		12,947,459	41
42	Tentative settlement (for contractors use only)			42
43	Balance due provider/program (line 40 minus the sum of lines 41, and 42)		-26,103	43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			44
PART B - MEDICAL AND OTHER HEALTH SERVICES TO BE COMPLETED BY CONTRACTOR				
90	Original outlier amount (see instructions)			90
91	Outlier reconciliation adjustment amount (see instructions)			91
92	The rate used to calculate the Time Value of Money			92
93	Time Value of Money (see instructions)			93
94	Total (sum of lines 91 and 93)			94
FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4030.2)				

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CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 420065	PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET E, PART B
Medicare -Title XVIII - Hospital			
Rev. 2 - 08-11			40-587

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CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 420065	PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET E-1, PART II

Medicare -Title XVIII - Hospital			
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION			
1	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I, line 14, column 15	8,618	1
2	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12	13,770	2
3	Medicare HMO days from Wkst S-3, Part I, column 6 line 2		3
4	Total inpatient bed days from S-3, Part I column 8 sum of lines 1, 8-12	32,392	4
5	Total hospital charges from Wkst C, Part I, column 8 line 200	573,484,928	5
6	Total hospital charity care charges from Wkst S-10, column 3 line 20	35,363,416	6
7	CAH only - The reasonable cost incurred for the purchase of certified HIT technology from Worksheet S-2, Part I line 168		7
8	Calcualtion of the HIT incentive payment (see instructions)		8
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH			
30	Initial/interim HIT payment(s).		30
31	Other Adjustments (specify)		31
32	Balance due provider (line 8 minus line 30 ± line 31)		32
FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4031.1)			
Rev. 2 - 08-11		40-589	

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BALANCE SHEET	Provider CCN: 420065	PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET G

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

	Assets (Omit cents)	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1	2	3	4	
	CURRENT ASSETS					
1	Cash on hand and in banks	5,450				1
2	Temporary investments			20,000		2
3	Notes receivable					3
4	Accounts receivable	28,187,144				4
5	Other receivables	2,627,292				5
6	Allowances for uncollectible notes and accounts receivable					6
7	Inventory	2,715,234				7
8	Prepaid expenses	186,136				8
9	Other current assets					9
10	Due from other funds	114,905,688				10
11	Total current assets (sum of lines 1-10)	148,626,944		20,000		11
	FIXED ASSETS					
12	Land	13,580,943				12
13	Land improvements	3,234,453				13
14	Accumulated depreciation	-1,900,734				14
15	Buildings	117,685,936				15
16	Accumulated depreciation	-28,370,156				16
17	Leasehold improvements					17
18	Accumulated depreciation					18
19	Fixed equipment	4,986,973				19
20	Accumulated depreciation	-4,417,147				20
21	Automobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	41,067,036				23
24	Accumulated depreciation	-25,952,470				24
25	Minor equipment depreciable	418,939				25
26	Accumulated depreciation	-408,771				26
27	HIT designated Assets					27
28	Accumulated depreciation					28
29	Minor equipment-nondepreciable					29
30	Total fixed assets (sum of lines 12-29)	119,925,008				30
	OTHER ASSETS					
31	Investments	296,839				31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	1,024,815				34
35	Total other assets (sum of lines 31-34)	1,321,654				35
36	Total assets (sum of lines 11, 30, and 35)	269,873,600		20,000		36
	Liabilities and Fund Balances (Omit cents)					
	CURRENT LIABILITIES					
37	Accounts payable	912,417				37
38	Salaries, wages, and fees payable	407,937				38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)					40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds	-111,720,056				43
44	Other current liabilities	4,291,514				44
45	Total current liabilities (sum of lines 37 thru 44)	-106,108,184				45
	LONG TERM LIABILITIES					
46	Mortgage payable					46
47	Notes payable	16,970,948				47
48	Unsecured loans					48
49	Other long term liabilities	17,823				49

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BALANCE SHEET		Provider CCN: 420065	PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET G	
(If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)					
	Assets (Omit cents)	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1	2	3	4	
50	Total long term liabilities (sum of lines 46 thru 49)	16,988,770				50
51	Total liabilities (sum of lines 45 and 50)	-89,119,416				51
CAPITAL ACCOUNTS						
52	General fund balance	358,993,024				52
53	Specific purpose fund					53
54	Donor created - endowment fund balance - restricted			20,000		54
55	Donor created - endowment fund balance - unrestricted					55
56	Governing body created - endowment fund balance					56
57	Plant fund balance - invested in plant					57
58	Plant fund balance - reserve for plant improvement, replacement, and expansion					58
59	Total fund balances (sum of lines 52 thru 58)	358,993,024		20,000		59
60	Total liabilities and fund balances (sum of lines 51 and 59)	269,873,600		20,000		60
FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4040)						
Rev. 2					40-601 - 08-11	

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STATEMENT OF CHANGES IN FUND BALANCES	Provider CCN: 420065	PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET G-1

		GENERAL FUND		SPECIFIC PURPOSE FUND		ENDOWMENT FUND		PLANT FUND		
		1	2	3	4	5	6	7	8	
1	Fund balances at beginning of period		319,638,304				20,000			1
2	Net income (loss) (from Worksheet G-3, line 29)		39,429,776							2
3	Total (sum of line 1 and line 2)		359,068,096				20,000			3
4										4
5										5
6										6
7										7
8										8
9										9
10	Total additions (sum of lines 4-9)									10
11	Subtotal (line 3 plus line 10)		359,068,096				20,000			11
12										12
13	CLOSE OUT DUE FROM PHY PRACTICE	75,063								13
14										14
15										15
16										16
17										17
18	Total deductions (sum of lines 12-17)		75,063							18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		358,993,024				20,000			19

FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4040)

40-602 - 08-11 Rev. 2

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STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider CCN: 420065	PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET G-2, PARTS I & II

PART I - PATIENT REVENUES

	REVENUE CENTER	INPATIENT	OUTPATIENT	TOTAL	
		1	2	3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	Hospital	67,746,672		67,746,672	1
2	Subprovider IPF				2
3	Subprovider IRF				3
4	Subprovider (Other)				4
5	Swing bed - SNF				5
6	Swing bed - NF				6
7	Skilled nursing facility				7
8	Nursing facility				8
9	Other long term care				9
10	Total general inpatient care services (sum of lines 1-9)	67,746,672		67,746,672	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	Intensive care unit	9,248,932		9,248,932	11
12	Coronary care unit				12
13	Burn intensive care unit				13
14	Surgical intensive care unit				14
15	Other special care (specify)				15
16	Total intensive care type inpatient hospital services (sum of of lines 11-15)	9,248,932		9,248,932	16
17	Total inpatient routine care services (sum of lines 10 and 16)	76,995,608		76,995,608	17
18	Ancillary services	171,243,056		171,243,056	18
19	Outpatient services		325,601,184	325,601,184	19
20	Rural Health Clinic (RHC)				20
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency				22
23	Ambulance				23
24	Outpatient rehabilitation providers				24
25	ASC				25
26	Hospice				26
27	Other (specify)	32,964	427,909	460,873	27
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	248,271,632	326,029,120	574,300,736	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Wkst. A, column 3, line 200)		138,150,096	29
30	Add (specify)			30
31				31
32				32
33				33
34				34
35				35
36	Total additions (sum of lines 30-35)			36
37	Deduct (specify)			37
38				38
39				39
40				40
41				41
42	Total deductions (sum of lines 37-41)			42
43	Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)		138,150,096	43

FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4040)

Rev. 2	08-11	40-603

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STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 420065	PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET G-3

	Description		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	574,300,736	1
2	Less contractual allowances and discounts on patients' accounts	399,187,200	2
3	Net patient revenues (line 1 minus line 2)	175,113,536	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	138,150,096	4
5	Net income from service to patients (line 3 minus line 4)	36,963,440	5
	OTHER INCOME		
6	Contributions, donations, bequests, etc		6
7	Income from investments		7
8	Revenues from telephone and telegraph service		8
9	Revenue from television and radio service		9
10	Purchase discounts		10
11	Rebates and refunds of expenses		11
12	Parking lot receipts		12
13	Revenue from laundry and linen service		13
14	Revenue from meals sold to employees and guests	989,988	14
15	Revenue from rental of living quarters		15
16	Revenue from sale of medical and surgical supplies to other than patients		16
17	Revenue from sale of drugs to other than patients		17
18	Revenue from sale of medical records and abstracts	448	18
19	Tuition (fees, sale of textbooks, uniforms, etc.)		19
20	Revenue from gifts, flowers, coffee shops, and canteen	392,663	20
21	Rental of vending machines		21
22	Rental of hospital space		22
23	Governmental appropriations		23
24	Other (specify)		24
24.00	OTHER RADIOLOGY INCOME	7,342	24.00
24.02	OTHER LAB INCOME	7,990	24.02
24.03	OTHER CPE INCOME	4,201	24.03
24.04	OTHER INCOME	588,898	24.04
24.05	ROUNDING	4	24.05
24.15	NON-OPERATING INCOME	1,330,073	24.15
25	Total other income (sum of lines 6-24)	3,321,607	25
26	Total (line 5 plus line 25)	40,285,048	26
27	Other expenses (specify)		27
27.00	NON OPERATING EXPENSE	855,272	27.00
28	Total other expenses (sum of line 27 and subscripts)	855,272	28
29	Net income (or loss) for the period (line 26 minus line 28)	39,429,776	29

FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4040)

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Cost report status - As Submitted
[Record code 1927 - 2010]

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 420065	PERIOD: FROM 01/01/2011 TO 12/31/2011	WORKSHEET L

Medicare -Title XVIII - Hospital

PART I - FULLY PROSPECTIVE METHOD

CAPITAL FEDERAL AMOUNT

1	Capital DRG other than outlier	1,809,259	1
2	Capital DRG outlier payments	73,693	2
3	Total inpatient days divided by number of days in the cost reporting period (see instructions)	88.75	3
4	Number of interns & residents (see instructions)		4
5	Indirect medical education percentage (see instructions)		5
6	Indirect medical education adjustment (line 1 times line 5)		6
7	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, Part A line 30) (see instructions)	0.074200	7
8	Percentage of Medicaid patient days to total days reported on Worksheet S-2, Part I, line 24. (see instructions)	0.185800	8
9	Sum of lines 7 and 8	0.260000	9
10	Allowable disproportionate share percentage (see instructions)	0.054100	10
11	Disproportionate share adjustment (line 10 times lines 1)	97,881	11
12	Total prospective capital payments (sum of lines 1-2, 6 and 11)	1,980,833	12

PART II - PAYMENT UNDER REASONABLE COST

1	Program inpatient routine capital cost (see instructions)		1
2	Program inpatient ancillary capital cost (see instructions)		2
3	Total inpatient program capital cost (line 1 plus line 2)		3
4	Capital cost payment factor (see instructions)		4
5	Total inpatient program capital cost (line 3 x line 4)		5

PART III - COMPUTATION OF EXCEPTION PAYMENTS

1	Program inpatient capital costs (see instructions)		1
2	Program inpatient capital costs for extraordinary circumstances (see instructions)		2
3	Net program inpatient capital costs (line 1 minus line 2)		3
4	Applicable exception percentage (see instructions)		4
5	Capital cost for comparison to payments (line 3 x line 4)		5
6	Percentage adjustment for extraordinary circumstances (see instructions)		6
7	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		7
8	Capital minimum payment level (line 5 plus line 7)		8
9	Current year capital payments (from Part I, line 12 as applicable)		9
10	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		10
11	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		11
12	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		12
13	Current year exception payment (if line 12 is positive, enter the amount on this line)		13
14	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		14
15	Current year allowable operating and capital payment (see instructions)		15
16	Current year operating and capital costs (see instructions)		16
17	Current year exception offset amount (see instructions)		17

FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTIONS 4064.1 - 4064.3)

40-646 - 08-11 Rev. 2

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Cost Report data

420002
PIEDMONT MEDICAL CENTER
222 SOUTH HERLONG AVENUE
ROCK HILL, SC 29732

[Electronic Record Code: 274727 - 1996]
Type of Facility: Short Term Acute Care
Type of Control: Proprietary, Corporation
Classification: Urban

Bed Size:	268
Total Annual Discharges:	12,771
Total Patient Revenue:	$585,545,756

Period: 06/01/2009 - 05/31/2010
Status: As Submitted

Fiscal Intermediary: TrailBlazer Health Enterprises, LLC

Medicare Inpatient Characteristics

DSH Ratio:	0.163000
DSH Amount:	$6,543,864
Outlier Amount:	$1,378,885
IME Amount:	$0
GME Amount:	$0
Total IP Reimbursement:	$51,738,137
Total IP Costs:	$54,769,666
NPR Date:	00/00/0000
NPR Settlement Amount:	$937,814
NPR Settlement Percent:	1.81 %

[Date Generated: 03/20/2013]

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Legend:

Identification
A hospital's Medicare provider number, name, and address are taken from Worksheet S-2. The Electronic Code is a code assigned by CostReportData.com to assist in resolving questions.

Type of Facility
The type of facility is determined from the last four digits of its Medicare provider number.

Type of Control
A hospital's type of control is taken from the HCRIS file.

Bed Size
The number of staffed beds is taken from Worksheet S-3, Part I, line 12, col.1. Cost report instructions define staffed beds as, "the number of beds available for use by patients at the end of the cost reporting period. A bed means an adult bed, pediatric bed, birthing room, or newborn bed maintained in a patient care area for lodging patients in acute, long term, or domiciliary areas of the hospital. Beds in labor room, birthing room, postanesthesia, postoperative recovery rooms, outpatient areas, emergency rooms, ancillary departments, nurses' and other staff residences, and other such areas which are regularly maintained and utilized for only a portion of the stay of patients (primarily for special procedures or not for inpatient lodging) are not termed a bed for these purposes.

Total Annual Discharges
The total number of inpatient discharges (all payors) is taken from Worksheet S-3, part I, line 12, column 15.

Total Patient Revenue
The total patient revenue (inpatient and outpatient) is taken from Worksheet G-2, part I, line 25, column 3.

Period
The beginning and ending dates for a cost report are taken from Worksheet S-2, line 17.

Status
The status of a cost report is taken from the HCRIS file.

Fiscal Intermediary
Medicare Fiscal Intermediaries (FIs) are private insurance companies that serve as the federal government's agents in the administration of the Medicare program, including the payment of claims. The name of the FI is obtained from a hospital's most recent Medicare cost report.

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Petitioner's Trial Exhibit 081A

Disproportionate Share (DSH Amount and DSH Ratio)
Medicare provides additional payment to hospitals that treat a disproportionate share of low-income patients. Qualifying hospitals receive a percentage increase in Medicare payments. This percentage increase varies depending on the ratio of low income patients and on certain statutory calculations. The Disproportionate SHare (DSH) ratio is taken from Worksheet E, Part A, line 4.03. The amount of DSH payments is from Worksheet E, Part A, line 4.04.

Outlier Amount
Medicare makes additional payments to hospitals for patients with costs that are extraordinarily high due to severity of illness and/or complicating conditions. The amount of outlier payments is from Worksheet E, Part A, line 2.01 (or line 2 for discharges occurring prior to October 1, 1997).

IME Amount
Teaching hospitals receive additional Medicare payment due to the indirect costs associated with medical education programs. These payments are intended to cover the costs of additional tests and procedures ordered by interns and residents over and above what would have been ordered by more experienced physicians. The amount of the Indirect Medical Education (IME) adjustment is from Worksheet E, Part A, line 3.24 (or line 3.03 for cost reporting periods ending on or before September 30, 1997).

GME Amount
Medicare pays a hospital for the costs of an approved direct Graduate Medical Education (GME) program. These costs include the direct cost of salaries and benefits for interns, residents, and teachers. The amount of GME payment is from Worksheet E, Part A, line 11.

Total IP Reimbursement
The total amount of Medicare inpatient reimbursement for the cost reporting period is from Worksheet E, Part A, line 16 for PPS hospitals or from Worksheet E-3, Part I, line 17 or Worksheet E-3, Part II, Line 30 for non-PPS hospitals.

Total IP Costs
Total IP Costs corresponding to Total IP Reimbursement are calculated in the cost report and summarized on Worksheet D-1, Part II, line 49.

NPR Date
At the close of its fiscal year, a provider must submit a cost report to the FI showing the costs it incurred during the fiscal year and the proportion of those costs to be allocated to Medicare. The FI reviews the cost report, determines the total amount of Medicare reimbursement due the provider and issues the provider a Notice of Program Reimbursement (NPR). The NPR date is obtained from the most recent cost report data (HCRIS). There is no NPR date for cost reports as submitted or as amended by the provider (see Status above).

NPR Settlement Amount
The NPR Settlement Amount is the Balance due provider/(Program). It is the difference between the Total IP Reimbursement (above) and the total interim payments for the cost reporting period less any tentative settlements previously made by the FI. The Balance due provider/(Program) is from Worksheet E, Part A, line 29 for PPS hospitals or from Worksheet E-3, Part I, line 20 or Worksheet E-3, Part II, Line 33 for non-PPS hospitals.

NPR Settlement Percentage
This NPR settlement percentage is the NPR settlement amount as a percentage of total inpatient reimbursement. (It is calculated from the data elements previously defined.)

Date Generated
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PIEDMONT MEDICAL CENTER - ROCK HILL, SC
Cost report status - As Submitted
[Record code 274727 - 1996]

HOSPITAL AND HOSPITAL HEALTHCARE COMPLEX IDENTIFICATION DATA	PROVIDER NO 420002	PERIOD FROM 06/01/2009 TO 05/31/2010	WORKSHEET S-2 PART I

Hospital and Hospital Health Care Complex Address:

1	Street: 222 SOUTH HERLONG AVENUE			P.O.Box:	1
1.01	City: ROCK HILL	State: SC	ZIP: 29732	County: YORK	1.01

Hospital and Hospital-Based Component Identification:

	Component	Component Name	Provider Number	NPI Number	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
	0	1	2	2.01	3	4	5	6	
2	Hospital	PIEDMONT MEDICAL CENTER	420002		07/01/66		P	P	2
3.00	Subprovider		42S002		05/01/92		P	O	3.00
4	Swing Beds-SNF								4
5	Swing Beds-NF								5
6	Hospital-Based SNF								6
7.00	Hospital-Based NF								7.00
8	Hospital-Based OLTC								8
9.00	Hospital-Based HHA								9.00
11.00	Separately Certified ASC								11.00
12.00	Hospital-Based Hospice								12.00
14.00	Hospital-Based Health Clinic								14.00
15.00	Outpatient Rehab. Clinic								15.00
16.00	Renal Dialysis								16.00

17	Cost Reporting Period	From: 06/01/2009	To: 05/31/2010		17
				1 2	
18	Type of Control (see instructions)			4	18

Type of Hospital/subprovider (see instructions)

19	Hospital	1	19
20.00	SubComponent 1 - 42S002	4	20.00

Other Information

21	Indicate if your hospital is either (1) urban or (2) rural at the end of the cost reporting period in column 1. If your hospital is geographically classified or located in a rural area, is your bed size in accordance with CFR 42 412.105 less than or equal to 100 beds, enter in column 2 "Y" for yes or "N" for no.						21
21.01	Does your facility qualify and is currently receiving payment for disproportionate share hospital adjustment in accordance with 42 CFR 412.106?Enter in column 1 "Y" for yes or "N" for no. Is this facility subject to the provisions of 42 CFR 412.106(c)(2) (Pickle amendment hospitals)? Enter in column 2 "Y" for yes or "N" for no.			Y			21.01
21.02	Has your facility received a new geographic reclassification status changes after the first day of the cost reporting period from rural to urban and vice versa? Enter "Y" for yes and "N" for no. If yes, enter in column 2 the effective date (mm/dd/yyyy) (See instructions)						21.02
21.03	Enter in column 1 your geographic location either (1) urban (2) rural If you answered urban in column 1 indicate if you received either a wage or standard geographic reclassification to a rural location, enter in column 2 "Y" for yes and "N" for no. If column 2 is yes enter in column 3 the effective date (mm/dd/yyyy) (see instruction). Does your facility contain 100 or fewer beds in accordance with 42 CFR 412.105? Enter in column 4 "Y" for yes and "N" for no. Enter in column 5 the providers actual MSA or CBSA	1	N		N	16740	21.03
21.04	For standard Geographic classification (not wage), what is your status at the beginning of the cost reporting period. Enter (1) urban and (2) rural.			1			21.04
21.05	For standard Geographic classification (not wage), what is your status at the end of the cost reporting period. Enter (1) urban and (2) rural.			1			21.05
21.06	Does this hospital qualifies for the three year transition (or applicable extension) of hold harmless payments for small rural hospital under the prospective payment system for hospital outpatient services under DRA §5105 or MIPPA §147, ACA §3121, or MMEA §108? (See instructions) Enter "Y" for yes, and "N" for no.			N			21.06
21.07	Does this hospital qualify as an SCH with 100 or fewer beds under MIPPA§147? Enter "Y" for yes and "N" for no.(See instructions) Is this an SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 or MMEA §108? Enter in colun 2 "Y" for yes or "N" for no.(See instructions)			N	N		21.07
21.08	Which method is used to determine Medicaid days on S-3, Part I, col. 5 Enter in column 1, "1" if it is based on date of admission, "2" if it based on census days, or "3" if it is based on date of discharge. Is this method different than the method used in the preceeding cost reporting period? Enter in column 2,"Y" for yes or "N" for no.						21.08
22	Are you classified as a referral center?			N			22
23	Does this facility operate a transplant center? If yes, enter certification date(s) in column 2 and termination date(s) in column 3 (mm/dd/yyyy) below:			N			23
23.01	If this is a Medicare certified kidney transplant center, enter the certification date in col. 2 and termination in col. 3.						23.01
23.02	If this is a Medicare certified heart transplant center, enter the certification date in col. 2 and termination in col. 3.						23.02
23.03	If this is a Medicare certified liver transplant center, enter the certification date in col. 2 and termination in col. 3.						23.03
23.04	If this is a Medicare certified lung transplant center, enter the certification date in col. 2 and termination in col. 3.						23.04
23.05	If Medicare pancreas transplant are performed see instructions for entering certification and termination date.						23.05

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HOSPITAL AND HOSPITAL HEALTHCARE COMPLEX IDENTIFICATION DATA	PROVIDER NO 420002	PERIOD FROM 06/01/2009 TO 05/31/2010	WORKSHEET S-2 PART I

23.06	If this is a Medicare certified intestinal transplant center, enter the certification date in col. 2 and termination in col. 3.					23.06
23.07	If this is a Medicare certified islet transplant center, enter the certification date in col. 2 and termination in col. 3.					23.07
24	If this is an organ procurement organization (OPO), enter the OPO number in column 2 termination date in col 3.					24
24.01	If this is a Medicare Transplant Center, enter CCN in col. 2, the certification or recertification date after (12/26/2007) in column 3 (mm/dd/yyyy).					24.01
25	Is this a teaching hospital or affiliated with a teaching hospital and you are receiving payments for I & R?	N				25
25.01	Is this teaching program approved in accordance with CMS Pub. 15-I, chapter 4?					25.01
25.02	If line 25.01 is yes, was Medicare participation and approved teaching program status in effect during the first month of the cost reporting period? If yes, complete Worksheet E-3, Part IV. If no, complete Worksheet D-2, Part II.					25.02
25.03	As a teaching hospital, did you elect cost reimbursement for physicians as defined in CMS Pub. 15-I, section 2148? If yes, complete Worksheet D-9.	N				25.03
25.04	Are you claiming costs on line 70 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N				25.04
25.05	Has your facility direct GME FTE cap (column 1) or IME FTE cap (column 2) been reduced under 42 CFR §413.79(c)(3) or 42 CFR §412.105(f)(1)(iv)(B)? Enter "Y" for yes and "N" for no in the applicable columns. (see instructions)	N	N			25.05
25.06	Has your facility received additional direct GME FTE resident cap slots or IME FTE residents cap slots under 42 CFR 413.79(c)(4)or 42 CFR 412.105(f)(1)(iv)(C)? Enter "Y" for yes and "N" for no in the applicable columns (see instructions).	N	N			25.06
25.07	Has your facility trained residents in non-provider setting during the cost reporting period? Enter "Y" for yes or "N" for no in column 1.					25.07
25.08	If line 25.07 is yes, enter in column 1 the weighted number of non-primary care FTE residents attributable to rotations occurring in all non-provider settings.					25.08
25.09	If line 25.07 is yes, use lines 25.09 through 25.59 as necessary to identify the program name in column 1, the program code in column 2, and the number unweighted primary care residents FTEs by program in column 3 for each primary care specialty program in which residents are trained.(see instructions)					25.09
26	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the C/R period Enter beginning and ending dates of SCH status on line 26.01. Subscript line 26.01 for number of periods in excess of one and enter subsequent dates					26
26.01	Enter the applicable SCH dates: (see instructions)	Beginning:	Ending:			26.01
27	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? If yes, enter the agreement date (mm/dd/yyyy) in column 2.	N				27
28	If this facility contains a hospital-based SNF, are all patients under managed care or there were no Medicare utilization enter "Y", if "N" complete lines 28.01 and 28.02.					28
28.01	If hospital-based SNF, enter appropriate transition period 1, 2, 3, or 100 in column 1. Enter in columns 2 and 3 the wage index adjustment factor before and on or after the October 1st (see instrctions)					28.01
28.02	Enter in column 1 the hospital based SNF facility specific rate (from your fiscal intermediary) if you have not transitioned to 100% SNP PPS payment. In column 2 enter the facility classification Urban(1) or Rural(2). In column 3, enter the SNF MSA code or two character state code if a Rural based facility. In column 4, enter the SNF CBSA code or two character state code if a Rural based facility					28.02
	A notice published in the "Federal Register" Vol. 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. Enter in column 1 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 6, column 3. Indicate in column 2 "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (See instructions)					
28.03	Staffing					28.03
28.04	Recruitment					28.04
28.05	Retention of employees					28.05
28.06	Training					28.06
28.07	Other (Specify)					28.07
29	Is this a rural hospital with a certified SNF which has fewer than 50 beds in the aggregate for both components, using the swing bed optional method of reimbursement?	N				29
30	Does this hospital qualify as a rural primary care hospital (RPCH)/Critical Access Hospital (CAH)? (see 42 CYR 485.606ff)	N				30
30.01	If so, is this the initial 12 month period for the facility operated as an RPCH/CAH? See 42 CFR 413.70.					30.01
30.02	If this facility qualifies as an RPCH/CAH, has it elected the all-inclusive method of payment for outpatient services? (See instructions)					30.02
30.03	If this facility qualifies as a CAH is it eligible for cost reimbursement for ambulance services? If yes, enter in column 2 the date of eligibility determination (date must be on or after 12/21/2000)					30.03
30.04	If this facility qualifies as a CAH is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes and "N" for no. If yes, the GME elimination would not be on Worksheet B, Part 1, column 26 and the program would be cost reimbursed. If yes also complete Worksheet D-2, Part II.					30.04
31	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR 412.113(c).	N				31
31.01		N				31.01
31.02		N				31.02
	Miscellaneous Cost Reporting information					
32	Is this an all-inclusive provider? If yes, enter the method used (A, B, or E only) in column 2.	N				32
33	Is this a new hospital under 42 CFR 412.300 PPS capital? Enter "Y for yes and "N" for no in column 1. If yes, for cost reporting periods beginning on or after October 1, 2002, do you elect to be reimbursed at 100% Federal capital payment? Enter "Y for yes and "N" for no in column 2.	N				33

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HOSPITAL AND HOSPITAL HEALTHCARE COMPLEX IDENTIFICATION DATA	PROVIDER NO 420002	PERIOD FROM 06/01/2009 TO 05/31/2010	WORKSHEET S-2 PART I

34	Is this a new hospital under 42 CFR 413.40(f)(1)(i) TEFRA?	N				34
35	Have you established a new subprovider (excluded unit) under 42 CFR 413.40(f)(1)(i)?	N				35
35.01		N				35.01
		V	XVIII	XIX		
	Prospective Payment System (PPS)-Capital	1	2	3		
36	Do you elect fully prospective payment methodology for capital costs? (See instructions)		Y			36
36.01	Does your facility qualify and receive payment for disproportionate share in accordance with 42 CFR 412.320? (See instructions)		Y			36.01
37	Do you elect hold harmless payment methodology for capital costs? (See instructions)		N			37
37.01	If you are a hold harmless provider, are you filing on the basis of 100% of the Federal rate?					37.01
	Title XIX inpatient services					
38	Do you have title XIX inpatient hospital services?	Y				38
38.01	Is this hospital reimbursed for title XIX through the cost report either in full or in part?					38.01
38.02	Does the title XIX program reduce capital following the Medicare methodology?					38.02
38.03	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (See instructions)	N				38.03
38.04	Do you operate an ICF/MF facility for purposes of title XIX?	N				38.04
40	Are there any related organization or home office costs as defined in CMS Pub. 15-1, Chapter 10? If yes, and this facility is part of a chain organization, enter in col. 2 the chain home office chain number. (See inst.) If this facility is part of a chain organization enter the name and address of the home office on lines 40.01-40.03.	Y	059111			40
40.01	Name: TENET HEALTHCARE CORP	FI/Contractor's Name: TRAILBLAZER HEALTH ENTERPRISES	FI/Contractor's Number: 04901			40.01
40.02	Street: 1445 ROSS AVENUE STE 1400	PO Box:				40.02
40.03	City: DALLAS	State: TX	Zip Code: 75202-2703			40.03
41	Are provider based physicians' costs included in Worksheet A?	Y				41
42	Are physical therapy services provided by outside suppliers?	Y				42
42.01	Are occupational therapy services provided by outside suppliers?	Y				42.01
42.02	Are speech pathology services provided by outside suppliers?	Y				42.02
43	Are respiratory therapy services provided by outside suppliers?	N				43
44	If you are claiming cost for renal services on Worksheet A, are they inpatient services only?	Y				44
45	Have you changed your cost allocation methodology from the previously filed cost report? See CMS Pub. 15-II, section 3617. If yes, enter the approval date (mm/dd/yyyy) in column 2.	N				45
45.01	Was there a change in the statistical basis?					45.01
45.02	Was there a change in the order of allocation?					45.02
45.03	Was there a change to the simplified cost finding method?					45.03
46	If you are participating in the NHCMQ demonstration project (must have a hospital-based SNF) during this cost reporting period, enter the phase (see instructions).					46

	If this facility contains a provider that qualifies for an exemption from the application of the lower of costs or charges, enter "Y" for each component and type of service that qualifies for the exemption. Enter "N" if not exempt. (See 42 CFR 413.13.)	Part A 1	Part B 2	Outpatient ASC 3	Outpatient Radiology 4	Outpatient Diagnostic 5	
47	Hospital	N	N	N	N	N	47
48	Subprovider	N	N	N	N	N	48
49	SNF						49
50	HHA						50
51	Outpatient Rehab. Providers (specify)						51

52	Does this hospital claim expenditures for extraordinary circumstances in accordance with 42 CFR 412.348(e)? (See instructions)	N			52
52.01	If you are a fully prospective or hold harmless provider are you eligible for the special exceptions payment pursuant to 42 CFR 412.348(g)? If yes, complete Worksheet L, Part IV.	N			52.01
53	If you are a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in this C/R period. Enter beginning and ending dates of MDH status on line 53.01. Subscript line 53.01 for number of periods in excess of one and enter subsequent dates.				53
53.01	MDH Period	Beginning:	Ending:		53.01
54	List amounts of malpractice premiums and paid losses:	Premiums: 226,398	Paid losses: 3,690,000	and/or Self Insurance:	54
54.01	Are malpractice premiums and paid losses reported in other than the Administrative and General cost center? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			54.01
55	Does your facility qualify for additional prospective payment in accordance with 42 CFR 412.107. Enter "Y" for yes and "N" for no.	N			55

		Date 0	Y or N 1	Limit 2	Y or N 3	Fees 4	
56	Are you claiming ambulance costs? If yes, enter in column 2 the payment limit provided from your fiscal intermediary and the applicable dates for those limits in column 0. If this is the first year of operation no entry is required in column 2. If column 1 is Y, enter Y or N in column 3 whether this is your first year of operations for rendering ambulance services. Enter in column 4, if applicable, the fee schedules amounts for the period beginning on or after 4/1/2002.		N				56
56.01	Enter subsequent ambulance payment limit as required. Subscript if more than 2 limits apply. Enter in column 4 the fee schedules amounts for initial or subsequent periods as applicable.						56.01
57	Are you claiming nursing and allied health costs? (See instructions)					N	57

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HOSPITAL AND HOSPITAL HEALTHCARE COMPLEX IDENTIFICATION DATA	PROVIDER NO 420002	PERIOD FROM 06/01/2009 TO 05/31/2010	WORKSHEET S-2 PART I

58	Are you an Inpatient Rehabilitation Facility (IRF), or do you contain an IRF subprovider? Enter in column 1 "Y" for yes and "N" for no. If yes have you made the election for 100% Federal PPS reimbursement? Enter in column 2 "Y for yes and "N" for no. This option is only available for cost reporting periods beginning on or after 1/1/2002 and before 10/1/2002.				N		58
58.01	If line 58 column 1 is Y, does the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter in column 1 "Y" for yes or "N" for no. Is the facility training residents in a new teaching programs in accordance with FR Vol. 70, No. 156 dated August 15, 2005 page 47929? Enter in column 2 "Y" for yes or "N" for no. If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions). If the current cost reporting period covers the beginning of the fourth enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5 . (see instructions)						58.01
59	Are you a Long Term Care Hospital (LTCH), or do you contain a LTCH subprovider? Enter in column 1 "Y" for yes and "N" for no. If yes, have you made the election for 100% Federal PPS reimbursement? Enter in column 2 "Y" for yes and "N" for no. (See instructions)				N		59
60	Are you an Inpatient Psychiatric Facility (IPF), or do you contain an IPF subprovider? Enter in column 1 "Y" for yes and "N" for no. If yes, is the IPF or IPF subprovider a new facility? Enter in column 2 "Y for yes and "N" for no. (see instructions)				Y		60
60.01	If line 60 column 1 is Y, does 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. Is the facility training residents in a new teaching programs in accordance with 42 CFR Sec. 412.424 (d)(1)(iii)(2)? Enter in column 2 "Y" for yes or "N" for no. If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions). If the current cost reporting period covers the beginning of the fourth enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5 . (see instructions)		N				60.01
Multicampus							
61	Is this facility part of a Multicampus hospital that has one or more campuses in different CBSA? Enter "Y" for yes and "N" for no.					N	61

	If line 61 is yes, enter the name in col. 0, County in col. 1, state in col. 2, Zip in col 3, CBSA in col. 4 and FTE/Campus in col. 5.	County	State	ZIP Code	CBSA	FTE/ Campus	
		1	2	3	4	5	
62	Name:						62
Settlement data							
63	Was there a change to the simplified cost finding method?				Y	08/31/10	63
Miscellaneous data							
64	Did this facility incur and report costs for implantable devices charged to patient? Enter in column 1 "Y" for yes or "N" for no.						64

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PIEDMONT MEDICAL CENTER - ROCK HILL, SC
Cost report status - As Submitted
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA	PROVIDER NO 420002	PERIOD FROM 06/01/2009 TO 05/31/2010	WORKSHEET S-3 PART I

	Component	No. of Beds	Bed Days Available	I/P Days / O/P Visits / Trips						Total All Patients	OBS Beds		Interns & Residents FTEs			Full Time Equivalent		Discharges				
				Title V	Title XVIII	Not Covered (LTAC only)	Title XIX				Admitted	Not Admitted	Total	Less I&R Replacing Non-Phys. Anest.	Net	Employees on Payroll	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
							Total	OBS Admitted	OBS Not Admitted													
		1	2	3	4	4.01	5	5.01	5.02	6	6.01	6.02	7	8	9	10	11	12	13	14	15	
1	Hospital Adults &Peds. (col 3,4,&5), exclude Swing Beds, OBS Bed, and Hospice Days	236	86,140		25,662		8,115			50,519									4,985	1,323	12,771	1
2	HMO				4,509		3,778															2
3	Hospital Adults &Peds Swing Bed SNF																					3
4	Hospital Adults & Peds Swing Bed NF																					4
5	Total Adults & Peds. (exclude OBS beds)	236	86,140		25,662		8,115			50,519												5
6	Intensive Care Unit	32	11,680		3,125		809			5,358												6
7	Coronary Care Unit																					7
8	Burn Intensive Care Unit																					8
9	Surgical Intensive Care Unit																					9
10.00	Other Special Care (specify)																					10.00
11	Nursery						2,564			5,304												11
12	Total (see instructions)	268	97,820		28,787		11,488			61,181						980.92			4,985	1,323	12,771	12
13	RPCH/CAH visits																					13
14.00	SubComponent 1 - 42S002	20	7,300		1,222		856			3,936						17.08			143	138	660	14.00
15	Skilled Nursing Facility																					15
16	Nursing Facility																					16
17	Other Long Term Care																					17
18	Home Health Agency																					18
20	ASC (Distinct Part)																					20
21	Hospice (Distinct Part)																					21
23	Outpatient Rehab. Provider (specify)																					23
24	RHC/FQHC (specify)																					24
25	Total (sum of lines 12-24)	288														998.00						25
26	Observation Bed Days						189	89	100	1,957	735	1,222										26
27	Ambulance Trips																					27
28	Employee discount days (see instru.)																					28
29	Labor & delivery days (see instructions)																					29

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HOSPITAL WAGE INDEX INFORMATION		PROVIDER NO.: 420002		PERIOD: FROM 06/01/2009 TO 05/31/2010		WORKSHEET S-3. PART II	
PART II - WAGE DATA	Amount Reported	Reclass. of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 1 ± col. 2)	Paid Hours Related to Salaries in col. 3	Average Hourly Wage (col. 3÷ col. 4)	Data Source	
	1	2	3	4	5	6	
SALARIES							
1 Total Salaries (see instructions)	63,462,406		63,462,406	2,351,671	26.99		1
2 Non-physician anesthetist Part A							2
3 Non-physician anesthetist Part B							3
4 Physician-Part A							4
4.01 Teaching physician salaries (see instructions)							4 01
5 Physician-Part B	480,050		480,050	9,541	50.31		5
5.01 Non-physician-Part B							5.01
6 Interns & residents (in an approved program)							6
6.01 Contractd Services I&R (see instructions)							6.01
7 Home office personnel							7
8 SNF							8
8.01 Excluded area salaries (see instructions)	6,627,325	28,893	6.656,218	300,229	22.17		8.01
OTHER WAGES & RELATED COSTS							
9 Contract labor (see instructions)	1,391,976		1,391,976	21,901	63.56		9
9.01 Pharmacy services under contract							9 01
9.02 Laboratory services under contract							9.02
9.03 Management and administrative services							9.03
10 Contract labor: physician-Part A	150,988		150,988	1,086	139.03		10
10.01 Teaching physician under contract (see instru.)							10.01
11 Home office salaries & wage-related costs	7,754,783		7,754,783	146,260	53.02		11
12 Home office: physician Part A							12
12.01 Teaching physician salaries (see instructions)							12.01
WAGE-RELATED COSTS							
13 Wage-related costs (core)	12,245,612		12,245,612			CMS 339	13
14 Wage-related costs (other)						CMS 339	14
15 Excluded areas	1,632,789		1,632,789			CMS 339	15
16 Non-physician anesthetist Part A						CMS 339	16
17 Non-physician anesthetist Part B						CMS 339	17
18 Physician Part A						CMS 339	18
18.01 Part A teaching physicians (see instructions)						CMS 339	18.01
19 Physician Part B	83,171		83,171			CMS 339	19
19.01 Wage-related costs (RHC/FQHC)						CMS 339	19.01
20 Interns & residents (in an approved program)						CMS 339	20
OVERHEAD COSTS - DIRECT SALARIES							
21 Employee Benefits	788,973		788,973	35,982	21.93		21
22 Administrative & General	5,938,359	-93,318	5,845,041	190,902	30.62		22
22.01 Administrative & General under contract (see inst.)	465,439		465,439	4,858	95.81		22.01
23 Maintenance & Repairs							23
24 Operation of Plant	666,534		666,534	32,834	20.30		24
25 Laundry & Linen Service							25
26 Housekeeping							26
26.01 Housekeeping under contract (see instructions)							26.01
27 Dietary							27
27.01 Dietary under contract (see inst.)							27.01
28 Cafeteria							28
29 Maintenance of Personnel							29
30 Nursing Administration	1,459,420		1,459,420	37,492	38.93		30
31 Central Services and Supply	469,010		469,010	36,566	12.83		31
32 Pharmacy	2,514,033		2,514,033	67,066	37.49		32
33 Medical Records & Medical Records Library	1,522,021		1,522,021	77,536	19.63		33
34 Social Service							34
35 Other General Service							35

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HOSPITAL WAGE INDEX INFORMATION		PROVIDER NO.: 420002		PERIOD FROM 06/01/2009 TO 05/31/2010		WORKSHEET S-3, PART III	
	Amount Reported	Reclass. of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 1 ± col. 2)	Paid Hours Related to Salaries in col. 3	Average Hourly Wage (col. 3 ÷ col. 4)	Data Source	
	1	2	3	4	5	6	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1 Net Salaries (see instructions)	63,447,795		63,447,795	2,346,988	27.03		1
2 Excluded area salaries (see instructions)	6,627,325	28,893	6,656,218	300,229	22.17		2
3 Subtotal salaries (line 1 minus line 2)	56,820,470	-28,893	56,791,577	2,046,759	27.75		3
4 Subtotal other wages & related costs (see inst.)	9,297,747		9,297,747	169,247	54.94		4
5 Subtotal wage-related costs (see inst.)	12,245,612		12,245,612		21.56		5
6 Total (sum of lines 3 thru 5)	78,363,829	-28,893	78,334,936	2,216,006	35.35		6
7 Net salaries (see instructions)							7
8 Excluded area salaries							8
9 Subtotal salaries (line 7 minus line 8)							9
10 Subtotal other wages & related costs (see inst.)							10
11 Subtotal wage-related costs (see inst.)							11
12 Total (sum of lines 9 thru 11)							12
13 Total overhead costs (see inst.)	13,823,789	-93,318	13,730,471	483,236	28.41		13

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HOSPITAL UNCOMPENSATED CARE DATA	PROVIDER NO: 420002	PERIOD: FROM: 06/01/2009 TO: 05/31/2010	WORKSHEET S-10	
Uncompensated Care Information				
1	Do you have a written charity policy?			1
2	Are patients write-offs identified as charity? If yes answer lines 2.01 thru 2.04			2
2.01	Is it at the time of admission?			2.01
2.02	Is it at the time of first billing?			2.02
2.03	Is it after some collection effort has been made?			2.03
2.04	Other methods of write-offs (specify)			2.04
3	Are charity write-offs made for partial bills?			3
4	Are charity determinations based upon administrative judgment without financial data?			4
5	Are charity determinations based upon income data only?			5
6	Are charity determinations based upon net worth (assets) data?			6
7	Are charity determinations based upon income and net worth data?			7
8	Does your accounting system separately identify bad debt and charity care? If yes answer 8.01			8
8.01	Do you separately account for inpatient and outpatient services?			8.01
9	Is discerning charity from bad debt a high priority in your institution? If no answer 9.01 thru 9.04			9
9.01	Is it because there is not enough staff to determine eligibility?			9.01
9.02	Is it because there is no financial incentive to separate charity from bad debt?			9.02
9.03	Is it because there is no clear directive policy on charity determination?			9.03
9.04	Is it because your institution does not deem the distinction important?			9.04
10	If charity determinations are made based upon income data, what is the maximum income that can be earned by patients (single without dependent) and still determined to be a charity write off??			10
11	If charity determinations are made based upon income data, is the income directly tied to Federal poverty level? If yes answer lines 11.01 thru 11.04			11
11.01	Is the percentage level used less than 100% of the Federal poverty level?			11.01
11.02	Is the percentage level used between 100% and 150% of the Federal poverty level?			11.02
11.03	Is the percentage level used between 150% and 200% of the Federal poverty level?			11.03
11.04	Is the percentage level greater than or equal to 200% of the Federal poverty level?			11.04
12	Are partial write-offs given to higher income patients on a gradual scale?			12
13	Is there charity consideration given to high net worth patients who have catastrophic or other extraordinary medical expenses?			13
14	Is your hospital State or local government owned? If yes answer line 14.01 and 14.02			14
14.01	Do you receive direct financial support from the government entity for the purpose of providing uncompensated care?			14.01
14.02	What percentage of the amount on line 14.01 is from government funding?			14.02
15	Do you receive restricted grants for rendering care to charity patients?			15
16	Are other non-restricted grants used to subsidize charity care?			16
Uncompensated Care Revenues				
17	Revenues from uncompensated care		1,520,853	17
17.01	Gross Medicaid Revenues		43,779,662	17.01
18	Revenues from State and local indigent care programs			18
19	Revenues related to SCHIP (see instructions)			19
20	Restricted grants		17,634	20
21	Non-restricted grants			21
22	Total Gross Uncompensated Care Revenues		45,318,149	22
Uncompensated Care Costs				
23	Total charges for patients covered by State and local indigent care programs		10,992,217	23
24	Cost to Charge Ratio (Wkst C, Part I, column 3 line 103, divided by column 8, line 103)		0.318952	24
25	Total State and local indigent care program cost (line 23 x line 24)		3,505,990	25
26	Total SCHIP charges from your records			26
27	Total SCHIP cost, (line 24 x line 26)			27
28	Total gross Medicaid charges from your records		45,552,823	28
29	Total gross Medicaid cost (line 24 x line 28)		14,529,164	29
30	Other uncompensated care charges from your records (see instructions)		57,556,405	30
31	Uncompensated care cost (line 24 x line 30)		18,357,730	31
32	Total uncompensated cost to the hospital (Sum of lines 25, 27, and 29)		18,035.154	32

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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES			PROVIDER NO: 420002		PERIOD: FROM 06/01/2009 TO 05/31/2010			WORKSHEET A	
		COST CENTER DESCRIPTIONS (omit cents)	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	RECLASSIFIED TRIAL BALANCE (col. 3 + col. 4)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 5 - col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	0100	Old Capital Related Costs-Buildings and Fixtures		3,263,515	3,263,515	366,912	3,630,427	-2,754,616	875,811	1
2	0200	Old Capital Related Costs-Movable Equipment		6,429,669	6,429,669	334,844	6,764,513	-6,428,256	336,257	2
3	0300	New Capital Related Costs-Buildings and Fixtures				1,078,534	1,078,534	2,354,042	3,432,576	3
4	0400	New Capital Related Costs-Movable Equipment				3,850,451	3,850,451	2,777,909	6,628,360	4
5	0500	Employee Benefits	788,973	767,478	1,556,451	-49,906	1,506,545		1,506,545	5
6.05	0600	Administrative & General	5,938,359	36,537,770	42,476,129	7,256,978	49,733,107	-2,137,656	47,595,451	6.05
7	0700	Maintenance and Repairs								7
8	0800	Operation of Plant	666,534	6,101,292	6,767,826	-6,113	6,761,713	-31,477	6,730,236	8
9	0900	Laundry and Linen Service		126,456	126,456	821,370	947,826		947,826	9
10	01000	Housekeeping		2,278,058	2,278,058	-20,285	2,257,773		2,257,773	10
11	1100	Dietary		2,356,358	2,356,358	-1,827,728	528,630		528,630	11
12	1200	Cafeteria				1,321,987	1,321,987		1,321,987	12
13	1300	Maintenance of Personnel								13
14	1400	Nursing Administration	1,459,420	409,614	1,869,034	-6,476	1,862,558		1,862,558	14
15	1500	Central Services and Supply	469,010	879,612	1,348,622	-318,802	1,029,820		1,029,820	15
16	1600	Pharmacy	2,514,033	7,695,855	10,209,888	-7,141,058	3,068,830		3,068,830	16
17	1700	Medical Records & Medical Records Library	1,522,021	1,698,522	3,220,543	-4,359	3,216,184	-117	3,216,067	17
18	1800	Social Service								18
19.00	1900	Other General Service (specify)								19.00
20	2000	Nonphysician Anesthetics								20
21	2100	Nursing School								21
22	2200	Intern & Res Service-Salary & Fringes (Approved)								22
23	2300	Intern & Res. Other Program Costs (Approved)								23
24	2400	Paramedical Ed. Program (specify)								24
		INPATIENT ROUTINE SERVICE COST CENTERS								
25	2500	Adults and Pediatrics (General Routine Care)	15,887,499	8,905,494	24,792,993	-1,165,383	23,627,610	-2,969,690	20,657,920	25
26	2600	Intensive Care Unit	3,493,663	1,239,003	4,732,666	-341,668	4,390,998	-8,666	4,382,332	26
27	2700	Coronary Care Unit								27
28	2800	Burn Intensive Care Unit								28
29	2900	Surgical Intensive Care Unit								29
30.00	3000	Other Special Care (specify)								30.00
31.00	3100	SubComponent 1 - 42S002	1,306,091	441,213	1,747,304	-118,127	1,629,177	-75,151	1,554,026	31.00
33	3300	Nursery	1,028,789	625,741	1,654,530	-143,133	1,511,397	-169,311	1,342,086	33
34	3400	Skilled Nursing Facility								34

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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES			PROVIDER NO: 420002		PERIOD: FROM 06/01/2009 TO 05/31/2010		WORKSHEET A		
		COST CENTER DESCRIPTIONS (omit cents)	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	RECLASSIFIED TRIAL BALANCE (col. 3 + col. 4)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 5 + col. 6)	
			1	2	3	4	5	6	7	
35.00	3500	Nursing Facility								35.00
36	3600	Other Long Term Care								36
		ANCILLARY SERVICE COST CENTERS								
37.05	3700	Operating Room	5,629,148	14,185,790	19,814,938	-12,125,471	7,689,467	-8,000	7,681,467	37.05
38	3800	Recovery Room								38
39.05	3900	Delivery Room & Labor Room	1,644,935	818,267	2,463,202	-356,412	2,106,790		2,106,790	39.05
40.00	4000	Anesthesiology								40.00
41.05	4100	Radiology-Diagnostic	3,362,253	3,860,270	7,222,523	-1,536,160	5,686,363	-212	5,686,151	41.05
42.00	4200	Radiology-Therapeutic								42.00
43	4300	Radioisotope								43
44.05	4400	Laboratory	2,509,490	5,253,913	7,763,403	-89,428	7,673,975	-239,715	7,434,260	44.05
44.45	4400	Vascular Lab	1,293,852	9,143,833	10,437,685	-8,337,946	2,099,739		2,099,739	44.45
45	4500	PBP Clinical Laboratory Services-Program Only								45
46.00	4600	Whole Blood & Packed Red Blood Cells								46.00
47	4700	Blood Storing, Processing, & Trans								47
48	4800	Intravenous Therapy	109,195	1,448,322	1,557,517	680,506	2,238,023		2,238,023	48
49.05	4900	Respiratory Therapy	1,498,470	1,044,501	2,542,971	-555,608	1,987,363		1,987,363	49.05
50.05	5000	Physical Therapy	519,570	259,627	779,197	-13,531	765,666		765,666	50.05
51	5100	Occupational Therapy	99,343	25,978	125,321	-7,445	117,876		117,876	51
52	5200	Speech Pathology	109,605	23,678	133,283	-2,327	130,956		130,956	52
53.05	5300	Electrocardiology	609,426	222,056	831,482	-13,752	817,730		817,730	53.05
54	5400	Electroencephalography	79,288	443,517	522,805	-3,443	519,362		519,362	54
55	5500	Medical Supplies Charged to Patients				11,076,551	11,076,551		11,076,551	55
55.30	5530	Implantable Devices Charged to Patients				11,443,861	11,443,861		11,443,861	55.30
56	5600	Drugs Charged to Patients				7,329,493	7,329,493		7,329,493	56
57	5700	Renal Dialysis		437,283	437,283	-15,192	422,091		422,091	57
58	5800	ASC (Non-Distinct Part)								58
59.30	5900	Other Ancillary Cost Centers	1,244,881	1,821,923	3,066,804	-1,011,210	2,055,594	-6,222	2,049,372	59.30
		OUTPATIENT SERVICE COST CENTERS								
60.05	6000	Clinic	979,264	964,304	1,943,568	-193,412	1,750,156	-834,409	915,747	60.05
61	6100	Emergency	3,378,060	3,511,653	6,889,713	-505,239	6,384,474	-1,337,422	5,047,052	61
62.00	6200	Observation Beds								62.00
63.00		Other Outpatient Service (specify)								63.00
		OTHER REIMBURSABLE COST CENTERS								
64	6400	Home Program Dialysis								64
65	6500	Ambulance Services	5,170,179	2,405,717	7,575,896	-203,395	7,372,501		7,372,501	65
66.00	6600	Durable Medical Equipment-Rented								66.00

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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES			PROVIDER NO: 420002			PERIOD: FROM 06/01/2009 TO 05/31/2010		WORKSHEET A		
COST CENTER DESCRIPTIONS (omit cents)			SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	RECLASSIFIED TRIAL BALANCE (col. 3 + col. 4)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 5 + col. 6)	
			1	2	3	4	5	6	7	
67.00	6700	Durable Medical Equipment-Sold								67.00
68	6800	Other Reimbursable (specify)								68
69.00	6900	Outpatient Rehabilitation Provider (specify)								69.00
70	7000	Intern-Resident Service (not appvd. tchng. prgm.)								70
71	7100	Home Health Agency								71
		SPECIAL PURPOSE COST CENTERS								
82	8200	Lung Acquisition								82
83	8300	Kidney Acquisition								83
84	8400	Livery Acquisition								84
85.00	8500	Heart Acquisition								85.00
86	8600	Other Organ Acquisition (specify)								86
88	8800	Interest Expense		16,194,500	16,194,500	92,994	16,287,494	-16,287,494		88
89	8900	Utilization Review-SNF								89
90	9000	Other Capital-Related Costs (see instructions)		10,762,367	10,762,367	-10,762,367				90
92	9200	Ambulatory Surgical Center (Distinct Part)								92
93	9300	Hospice								93
94	9400	Other Special Purpose (specify)								94
95		SUBTOTALS (sum of lines 1-94)	63,311,351	152,583,149	215,894,500	-1,220,895	214,673,605	-28,156,463	186,517,142	95
		NONREIMBURSABLE COST CENTERS								
96	9600	Gift, Flower, Coffee Shop, & Canteen								96
97	9700	Research								97
98	9800	Physicians' Private Offices								98
99	9900	Nonpaid Workers								99
100		Other Nonreimbursable (specify)	151,055	683,995	835,050	1,220,895	2,055,945		2,055,945	100
101		TOTAL (sum of lines 95-100)	63,462,406	153,267,144	216,729,550		216,729,550	-28,156,463	188,573,087	101

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ANALYSIS OF CHANGES DURING COST REPORTING PERIOD IN CAPITAL ASSET BALANCES OF HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX CERTIFIED TO PARTICIPATE IN HEALTH CARE PROGRAMS	PROVIDER NO: 420002	PERIOD: FROM 06/01/2009 TO 05/31/2010	WORKSHEET A7 Parts 1 & 2

PART I - ANALYSIS OF CHANGES IN OLD CAPITAL ASSET BALANCES

	Description	Beginning Balances	Acquisitions			Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
			Purchases	Donation	Total				
		1	2	3	4	5	6	7	
1	Land								1
2	Land Improvements	496,927					496,927		2
3	Buildings and Fixtures	21,162,536					21,162,536		3
4	Building Improvements	39,502					39,502		4
5	Fixed Equipment	2,052,413					2,052,413		5
6	Movable Equipment	21,675,425					21,675,425		6
7	Subtotal (sum of lines 1-6)	45,426,803					45,426,803		7
8	Reconciling Items								8
9	Total (line 7 minus line 8)	45,426,803					45,426,803		9

PART II - ANALYSIS OF CHANGES IN NEW CAPITAL ASSET BALANCES

	Description	Beginning Balances	Acquisitions			Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
			Purchases	Donation	Total				
		1	2	3	4	5	6	7	
1	Land								1
2	Land Improvements	1,192,489	21		21		1,192,510		2
3	Buildings and Fixtures	65,703,934	512,088		512,088	476,414	65,739,608		3
4	Building Improvements	675,729	17,300		17,300	17,300	675,729		4
5	Fixed Equipment	2,029,258	224,575		224,575	44,741	2,209,092		5
6	Movable Equipment	58,663,928				5,844,415	52,819,513		6
7	Subtotal (sum of lines 1-6)	128,265,338	753,984		753,984	6,382,870	122,636,452		7
8	Reconciling Items								8
9	Total (line 7 minus line 8)	128,265,338	753,984		753,984	6,382,870	122,636,452		9

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RECONCILIATION OF CAPITAL COSTS CENTERS	PROVIDER NO: 420002	PERIOD: FROM 06/01/2009 TO 05/31/2010	WORKSHEET A7, PARTS III & IV

PART III - RECONCILIATION OF CAPITAL COSTS CENTERS

	Description	COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instru.)	Insurance	Taxes	Other Capital-Related Costs	Total (sum of cols. 5-7)	
		1	2	3	4	5	6	7	8	
1	Old Capital Related Costs-Buildings and Fixtures	23,751,378		23,751,378		44,503	322,409		366,912	1
2	Old Capital Related Costs-Movable Equipment	21,675,425		21,675,425		40,614	294,230		334,844	2
3	New Capital Related Costs-Buildings and Fixtures	69,816,939		69,816,939		130,817	947,717		1,078,534	3
4	New Capital Related Costs-Movable Equipment	52,819,512		52,819,512		98,969	716,991		815,960	4
5	Total (sum of lines 1-4)	168,063,254		168,063,254		314,903	2,281,347		2,596,250	5

	Description *	SUMMARY OF OLD AND NEW CAPITAL							
		Depreciation	Lease	Interest	Insurance (see instru.)	Taxes (see instru.)	Other Capital-Related Costs (see instru.)	Total (1) (sum of cols. 9-14)	
		9	10	11	12	13	14	15	
1	Old Capital Related Costs-Buildings and Fixtures	508,899						875,811	1
2	Old Capital Related Costs-Movable Equipment	1,413						336,257	2
3	New Capital Related Costs-Buildings and Fixtures	2,354,042						3,432,576	3
4	New Capital Related Costs-Movable Equipment	2,777,909	3,034,491					6,628,360	4
5	Total (sum of lines 1-4)	5,642,263	3,034,491					11,273,004	5

(1) The amounts on lines 1 thru 4 must equal the corresponding amounts on Worksheet A, column 7, lines 1 thru 4. Columns 9 through 14 should include related Worksheet A-6 reclassificatons, Worksheet A-8 adjustments, and Worksheet A-8-1 related organizations and home office costs. (See instructions.)

PART IV - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 THRU 4

	Description *	SUMMARY OF OLD AND NEW CAPITAL							
		Depreciation	Lease	Interest	Insurance (see instru.)	Taxes (see instru.)	Other Capital-Related Costs (see instru)	Total (1) (sum of cols. 9-14)	
		9	10	11	12	13	14	15	
1	Old Capital Related Costs-Buildings and Fixtures	3,263,515						3,263,515	1
2	Old Capital Related Costs-Movable Equipment	6,429,669						6,429,669	2
3	New Capital Related Costs-Buildings and Fixtures								3
4	New Capital Related Costs-Movable Equipment								4
5	Total (sum of lines 1-4)	9,693,184						9,693,184	5

(1) The amount in columns 9 thru 14 must equal the amount on Worksheet A, column 2, lines 1 thru 4. Enter in each column the approporiate amounts including any directly assigned cost which may have been included in Worksheet A, column 2, lines 1 thru 4. All lines numbers except line 5 are to be consistent with Worksheet A line numbers for capital cost centers.

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	ADJUSTMENTS TO EXPENSES	PROVIDER NO: 420002	PERIOD: FROM: 06/01/2009 TO: 05/31/2010	WORKSHEET A-8			
	DESCRIPTION (1)	(2)		Epense Classification on Worksheet A to/from which the amount is to be adjusted		Wkst. A-7 Ref.	
		BASIS/CODE	AMOUNT	COST CENTER		LINE #	
		1	2	3	4	5	
1	Investment income - old buildings and fixtures (chapter 2)			Old Buildings and Fixtures	1		1
2	Investment income - old movable equipment (chapter 2)			Old Movable Equipment	2		2
3	Investment income - new buildings and fixtures (chapter 2)			New Buildings and Fixtures	3		3
4	Investment income - new movable equipment (chapter 2)			New Movable Equipment	4		4
5	Investment income - other (chapter 2)		-1,209				5
6	Trade, quantity, and time discounts (chapter 8)		-62,600				6
7	Refunds and rebates of expenses (chapter 8)		-33,618				7
8	Rental of provider space by suppliers (chapter 8)						8
9	Telephone services (pay stations excluded) (chapter 21)		-40,658				9
10	Television and radio service (chapter 21)		-30,267				10
11	Parking lot (chapter 21)						11
12	Provider-based physician adjustment	Wkst A-8-2	-4,882,327				12
13	Sale of scrap, waste, etc. (chapter 23)						13
14	Related organization transactions (chapter 10)	Wkst A-8-1	-14,674,974				14
15	Laundry and linen service						15
16	Cafeteria-employees and guests						16
17	Rental of quarters to employee and others						17
18	Sale of medical and surgical supplies to other than patients						18
19	Sale of drugs to other than patients						19
20	Sale of medical records and abstracts						20
21	Nursing school (tuition, fees, books, etc.)						21
22	Vending machines						22
23	Income from imposition of interest, finance or penalty charges (chapter 21)						23
24	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments						24
25	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	Wkst A-8-3 Wkst A-8-4		Respiratory Therapy	46		25
26	Adjustment for physical therapy costs in excess of limitation (chapter 14)	Wkst A-8-3 Wkst A-8-4		Physical Therapy	50		26
27	Adjustment for HHA physical therapy costs in excess of limitation	Wkst A-8-3		HHA	71		27
28	Utilization review - physicians' compensation (chapter 21)			Utilization Review - SNF	89		28
29	Depreciation - old buildings and fixtures		-2,669,573	Old Buildings and Fixtures	1		29
30	Depreciation - old movable equipment		-6,428,256	Old Movable Equipment	2		30
31	Depreciation - new buildings and fixtures		1,901,012	New Buildings and Fixtures	3		31
32	Depreciation - new movable equipment		2,811,527	New Movable Equipment	4		32
33	Non-physician Anesthetist			Nonphysician Anesthetist	26		33
34	Physicians' assistant						34
35	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	Wkst A-8-4		Occupational Therapy	51		35
36	Adjustment for speech pathology costs in excess of limitation (chapter 14)	Wkst A-8-4		Speech Pathology	52		36
37	Other adjustments (specify) (3)		-4,045,520				37
50	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 101.)		-28,156,463				50

(1) Description - all chapter references in this column pertain to HCFA Pub. 15-I. (2) Basis for adjustment (see instructions). A. Costs - if cost, including applicable overhead, can be determined. B. Amount Received - if cost cannot be determined. (3) Additional adjustments may be made on lines 37 thru 49 and subscripts thereof. Note:See instructions for column 5 referencing to Worksheet A-7.

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Statement of Costs of Services from Related Organizations and Home Office Costs	PROVIDER NO: 420002	PERIOD: FROM: 06/01/2009 TO: 05/31/2010	WORKSHEET A-8-1 Part A

A. Costs incurred and adjustments required as a result of transactions with related organizations or the claiming of home office costs:

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount included in Wkst. A, column 5	Net Adjustments (col.4 - col.5) *	Wkst. A-7 Ref.	
	1	2	3	4	5	6	7	
1	88		INTERCOMPANY INTEREST		16,287,494	-16,287,494		1
2	6		HOME OFFICE	10,277,140	9,117,650	1,159,490		2
3	3		HOME OFFICE - DIRECT NEW COC	453,030		453,030	9	3
4.00	6		INTERCOMPANY JOURNAL ENTRIES	12,086,754	12,086,754			4.00
5	TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet A-8, column 2, line 14.			22,816,924	37,491,898	-14,674,974		5
	*The amounts on lines 1-4 and subscripts as appropriate are transfered in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost.For related organizational or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.							

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Statement of Costs of Services from Related Organizations and Home Office Costs	PROVIDER NO: 420002	PERIOD: FROM: 06/01/2009 TO: 05/31/2010	WORKSHEET A-8-1 Part B

B. Interrelationship to related organization(s) and/or home office:

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet. This information is used by the Health Care Financing Administration and its intermediaries in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act.If you do not provide all or any part of the requested information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

				Related Organization(s) and/or Home Office			
	Symbol (1)	Name	Percentage of Ownership		Percentage of Ownership	Type of Business	
	1	2	3	4	5	6	
1	B						1
2	B		100	TENET HEALTHCARE CORPORAT		PARENT COMPANY	2
3	B		100	S.O.S.		CREDIT AND COLLECTION	3
4	C		46	BROADLANE INC.		GROUP PURCHASING ORGANIZA	4
	(1) Use the following symbols to indicate interrelationship to related organizations:						
		A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.					
		B. Corporation, partnership, or other organization has financial interest in provider.					
		C. Provider has financial interest in corporation, partnership, or other organization.					
		D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.					
		E. Individual is director, officer, administrator, or key person of provider and related organization.					
		F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.					
		G. Other (financial or non-financial) specify _____					

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COST ALLOCATION - GENERAL SERVICE COSTS | PROVIDER NO.: 420002 | PERIOD: FROM 06/01/2009 TO 05/31/2010 | WORKSHEET B. PART I

	COST CENTER DESCRIPTIONS	NET EXPENSES FOR COST ALLOCATION (from Wkst. A, col. 7)	OLD CAPITAL RELATED COSTS		NEW CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	SUBTOTAL (cols. 0-5)	ADMINIS-TRATIVE & GENERAL	MAIN-TENANCE & REPAIRS	OPERATION OF PLANT	
			BLDGS. & FIXTURES	MOVABLE EQUIPMENT	BLDGS. & FIXTURES	MOVABLE EQUIPMENT						
		0	1	2	3	4	5	5a	6	7	8	
	GENERAL SERVICE COST CENTERS											
1	Old Capital Related Costs-Buildings and Fixtures	875,811	875,811									1
2	Old Capital Related Costs-Movable Equipment	336,257		336,257								2
3	New Capital Related Costs-Buildings and Fixtures	3,432,576			3,432,576							3
4	New Capital Related Costs-Movable Equipment	6,628,360				6,628,360						4
5	Employee Benefits	1,506,545	11,554	4,167	45,283	82,147	1,649,696					5
6.05	Administrative & General	47,595,451	53,493	19,295	209,658	380,338	153,853	48,412,088	48,412,088			6.05
7	Maintenance and Repairs											7
8	Operation of Plant	6,730,236	196,892	71,017	771,681	1,399,899	17,545	9,187,270	3,173,311		12,360,581	8
9	Laundry and Linen Service	947,826	10,647	3,840	41,728	75,698		1,079,739	372,945		214,376	9
10	Housekeeping	2,257,773	3,413	1,231	13,377	24,266		2,300,060	794,448		68,722	10
11	Dietary	528,630	26,152	9,433	102,498	185,941		852,654	294,509		526,583	11
12	Cafeteria	1,321,987						1,321,987	456,618			12
13	Maintenance of Personnel											13
14	Nursing Administration	1,862,558	9,096	3,281	35,651	64,675	38,415	2,013,676	695,530		183,159	14
15	Central Services and Supply	1,029,820	23,371	8,430	91,599	166,168	12,345	1,331,733	459,985		470,588	15
16	Pharmacy	3,068,830	7,600	2,741	29,788	54,038	66,174	3,229,171	1,115,365		153,034	16
17	Medical Records and Medical Records Library	3,216,067	4,380	1,580	17,166	31,141	40,063	3,310,397	1,143,421		88,191	17
18	Social Service											18
19.00	Other General Service (specify)											19.00
20	Nonphysician Anesthetists											20
21	Nursing School											21
22	Intern &Res. Service-Salary &Fringes (Approved)											22
23	Intern &Res. Other Program Costs (Approved)											23
24	Paramedical Ed. Program (specify)											24
	INPATIENT ROUTINE SERVICE COST CENTERS											
25	Adults and Pediatrics (General Routine Care)	20,657,920	197,022	71,062	772,185	1,400,816	418,198	23,517,203	8,122,970		3,967,110	25
26	Intensive Care Unit	4,382,332	33,244	11,991	130,292	236,361	91,960	4,886,180	1,687,701		669,375	26

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COST ALLOCATION - GENERAL SERVICE COSTS							PROVIDER NO.: 420002		PERIOD: FROM 06/01/2009 TO 05/31/2010		WORKSHEET B, PART I	
COST CENTER DESCRIPTIONS		NET EXPENSES FOR COST ALLOCATION (from Wkst. A, col. 7)	OLD CAPITAL RELATED COSTS		NEW CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	SUBTOTAL (cols. 0-5)	ADMINIS-TRATIVE & GENERAL	MAIN-TENANCE & REPAIRS	OPERATION OF PLANT	
			BLDGS. & FIXTURES	MOVABLE EQUIPMENT	BLDGS. & FIXTURES	MOVABLE EQUIPMENT						
		0	1	2	3	4	5	5a	6	7	8	
27	Coronary Care Unit											27
28	Burn Intensive Care Unit											28
29	Surgical Intensive Care Unit											29
30.00	Other Special Care (specify)											30 00
31.00	SubComponent 1 - 42S002	1,554,026	18,097	6,528	70,929	128,672	32,683	1,810,935	625,502		364,398	31.00
33	Nursery	1,342,086	26,721	9,638	104,726	189,983	27,080	1,700,234	587,266		538,031	33
34	Skilled Nursery Facility											34
35 00	Nursing Facility											35.00
36	Other Long Term Care											36
	ANCILLARY SERVICE COST CENTERS											
37.05	Operating Room	7,681,467	76,350	27,539	299,241	542,850	148,170	8,775,617	3,031,124		1,537,348	37.05
38	Recovery Room											38
39.05	Delivery Room & Labor Room	2,106,790	25,458	9,183	99,779	181,007	43,298	2,465,515	851,596		512,613	39.05
40 00	Anesthesiology											40 00
41.05	Radiology-Diagnostic	5,686,151	31,813	12,372	124,685	243,874	88,501	6,187,396	2,137,145		640,568	41.05
42 00	Radiology-Therapeutic											42.00
43	Radioisotope											43
44.05	Laboratory	7,434,260	16,611	5,991	65,102	118,101	66,055	7,706,120	2,661,717		334,462	44.05
44.45	Vascular Lab	2,099,739	22,494	8,113	88,161	159,932	34,057	2,412,496	833,283		452,928	44.45
45	PBP Clinical Laboratory Services-Program Only											45
46 00	Whole Blood & Packed Red Blood Cells											46.00
47	Blood Storing, Processing, & Trans.											47
48	Intravenous Therapy	2,238,023	10,497	3,786	41,141	74,634	2,874	2,370,955	818,935		211,364	48
49.05	Respiratory Therapy	1,987,363	5,687	2,051	22,290	40,435	39,443	2,097,269	724,403		114,512	49.05
50 05	Physical Therapy	765,666	2,362	852	9,257	16,794	13,676	808,607	279,295		47,560	50.05
51	Occupational Therapy	117,876					2,615	120,491	41,618			51
52	Speech Pathology	130,956					2,885	133,841	46,229			52
53.05	Electrocardiology	817,730	2,283	824	8,950	16,235	16,041	862,063	297,759		45,978	53.05
54	Electroencephalography	519,362	260	1,970	1,019	38,840	2,087	563,538	194,648		5,234	54
55	Medical Supplies Charged to Patients	11,076,551						11,076,551	3,825,874			55

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COST ALLOCATION - GENERAL SERVICE COSTS							PROVIDER NO.: 420002		PERIOD: FROM 06/01/2009 TO 05/31/2010		WORKSHEET B. PART I	
COST CENTER DESCRIPTIONS		NET EXPENSES FOR COST ALLOCATION (from Wksht. A. col. 7)	OLD CAPITAL RELATED COSTS		NEW CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	SUBTOTAL (cols. 0-5)	ADMINIS-TRATIVE & GENERAL	MAIN-TENANCE & REPAIRS	OPERATION OF PLANT	
			BLDGS. & FIXTURES	MOVABLE EQUIPMENT	BLDGS. & FIXTURES	MOVABLE EQUIPMENT						
		0	1	2	3	4	5	5a	6	7	8	
55 30	Implantable Devices Charged to Patients	11,443,861						11,443,861	3,952,744			55.30
56	Drugs Charged to Patients	7,329,493						7,329,493	2,531,629			56
57	Renal Dialysis	422,091	1,593	575	6,245	11,329		441,833	152,610		32,083	57
58	ASAC (Non-Distinct Part)											58
59 30	Other Ancillary Cost Centers	2,049,372	3,594	9,530	14,088	187,855	34,464	2,298,903	794,049		72,375	59.30
	OUTPATIENT SERVICE COST CENTERS											
60 05	Clinic	915,747		5,124		101,015	25,776	1,047,662	361,866			60 05
61	Emergency	5,047,052	29,285	10,563	114,775	208,212	88,917	5,498,804	1,899,303		589,657	61
62.00	Observation Beds											62.00
63.00	Other Outpatient Service (specify)											63.00
	OTHER REIMBURSABLE COST CENTERS											
64	Home Program Dialysis											64
65	Ambulance Services	7,372,501	22,651	13,110	88,777	258,421	136,089	7,891,549	2,725,765		456,091	65
66 00	Durable Medical Equipment-Rented											66.00
67.00	Durable Medical Equipment-Sold											67.00
68	Other Reimbursable (specify)											68
69.00	Outpatient Rehabilitation Provider (specify)											69.00
70	Intern-Resident Service (not apprvd. tching. prgm.)											70
71	Home Health Agency											71
	SPECIAL PURPOSE COST CENTERS											
82	Lung Acquisition											82
83	Kidney Acquisition											83
84	Liver Acquisition											84
85 00	Heart Acquisition											85.00
86	Other Organ Acquisition (specify)											86
92	Ambulatory Surgical Center (Distinct Part)											92
93	Hospice											93
94	Other Special Purpose (specify)											94
95	SUBTOTALS (sum of lines 1-94)	186,517,142	872,620	335,817	3,420,071	6,619,677	1,643,264	186,485,891	47,691,163		12,296,340	95
	NONREIMBURSABLE COST CENTERS											

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COST ALLOCATION - GENERAL SERVICE COSTS							PROVIDER NO.: 420002		PERIOD: FROM 06/01/2009 TO 05/31/2010		WORKSHEET B. PART I	
COST CENTER DESCRIPTIONS		NET EXPENSES FOR COST ALLOCATION (from Wksht. A, col. 7)	OLD CAPITAL RELATED COSTS		NEW CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	SUBTOTAL (cols. 0-5)	ADMINIS-TRATIVE & GENERAL	MAIN-TENANCE & REPAIRS	OPERATION OF PLANT	
			BLDGS. & FIXTURES	MOVABLE EQUIPMENT	BLDGS. & FIXTURES	MOVABLE EQUIPMENT						
		0	1	2	3	4	5	5a	6	7	8	
96	Gift, Flower, Coffee Shop, &Canteen		1,603		6,282			7,885	2,724		32,271	96
97	Research											97
98	Physicians' Private Offices		367		1,437			1,804	623		7,381	98
99	Nonpaid Workers											99
100	Other Nonreimbursable (specify)	2,055,945	1,221	440	4,786	8,683	6,432	2,077,507	717,578		24,589	100
101	Cross Foot Adjustments											101
102	Negative Cost Centers											102
103	Total (sum of lines 95-102)	188,573,087	875,811	336,257	3,432,576	6,628,360	1,649,696	188,573,087	48,412,088		12,360,581	103

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COST ALLOCATION - GENERAL SERVICE COSTS					PROVIDER NO.: 420002		PERIOD: FROM 06/01/2009 TO 05/31/2010		WORKSHEET B. PART I			
	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	MAIN-TENANCE OF PERSONNEL	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & MEDICAL LIBRARY	SOCIAL SERVICE	
		9	10	11	12	13	14	15	16	17	18	
	GENERAL SERVICE COST CENTERS											
1	Old Capital Related Costs-Buildings and Fixtures											1
2	Old Capital Related Costs-Movable Equipment											2
3	New Capital Related Costs-Buildings and Fixtures											3
4	New Capital Related Costs-Movable Equipment											4
5	Employee Benefits											5
6 05	Administrative & General											6 05
7	Maintenance and Repairs											7
8	Operation of Plant											8
9	Laundry and Linen Service	1,667,060										9
10	Housekeeping		3,163,230									10
11	Dietary	137,918	1,811,664									11
12	Cafeteria				1,778,605							12
13	Maintenance of Personnel											13
14	Nursing Administration		47,972		46,218		2,986,555					14
15	Central Services and Supply		123,252		14,853			2,400,411				15
16	Pharmacy		40,081		79,617				4,617,268			16
17	Medical Records and Medical Records Library		23,098		48,201					4,613,308		17
18	Social Service											18
19.00	Other General Service (specify)											19.00
20	Nonphysician Anesthetists											20
21	Nursing School											21
22	Intern &Res. Service-Salary &Fringes (Approved)											22
23	Intern &Res. Other Program Costs (Approved)											23
24	Paramedical Ed. Program (specify)											24
	INPATIENT ROUTINE SERVICE COST CENTERS											
25	Adults and Pediatrics (General Routine Care)	1,293,336	1,039,033	1,405,523	503,157		1,424,988			460,606		25
26	Intensive Care Unit	137,170	175,317	149,069	110,641		284,536			100,565		26

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COST ALLOCATION - GENERAL SERVICE COSTS					PROVIDER NO.: 420002		PERIOD: FROM 06/01/2009 TO 05/31/2010		WORKSHEET B. PART I			
COST CENTER DESCRIPTIONS		LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	MAIN-TENANCE OF PERSONNEL	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & MEDICAL LIBRARY	SOCIAL SERVICE	
		9	10	11	12	13	14	15	16	17	18	
27	Coronary Care Unit											27
28	Burn Intensive Care Unit											28
29	Surgical Intensive Care Unit											29
30 00	Other Special Care (specify)											30 00
31.00	SubComponent 1 - 42S002	100,766	95,440	109,506	39,322		124,771			39,329		31 00
33	Nursery	135,788	140,916	147,566	32,581		103,490			28,687		33
34	Skilled Nursery Facility											34
35 00	Nursing Facility											35 00
36	Other Long Term Care											36
	ANCILLARY SERVICE COST CENTERS											
37.05	Operating Room		402,649		178,269		407,496			368,698		37.05
38	Recovery Room											38
39.05	Delivery Room & Labor Room		134,259		52,093		126,855			56,478		39.05
40 00	Anesthesiology											40 00
41.05	Radiology-Diagnostic		167,772		106,479		19,497			494,270		41.05
42.00	Radiology-Therapeutic											42.00
43	Radioisotope											43
44.05	Laboratory		87,599		79,473					417,035		44.05
44.45	Vascular Lab		118,627		40,975		90,308			290,561		44.45
45	PBP Clinical Laboratory Services-Program Only											45
46 00	Whole Blood & Packed Red Blood Cells											46 00
47	Blood Storing, Processing, & Trans.											47
48	Intravenous Therapy		55,359		3,458		7,643			246,766		48
49 05	Respiratory Therapy		29,992		47,455		7,906			85,130		49 05
50.05	Physical Therapy		12,456		16,454					22,378		50.05
51	Occupational Therapy				3,146					3,842		51
52	Speech Pathology				3,471					4,152		52
53.05	Electrocardiology		12,042		19,300		9,820			82,147		53 05
54	Electroencephalography		1,371		2,511		74			17,346		54
55	Medical Supplies Charged to Patients							1,687,249		554,551		55

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COST ALLOCATION - GENERAL SERVICE COSTS					PROVIDER NO.: 420002		PERIOD: FROM 06/01/2009 TO 05/31/2010		WORKSHEET B. PART I			
COST CENTER DESCRIPTIONS		LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	MAIN-TENANCE OF PERSONNEL	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & MEDICAL LIBRARY	SOCIAL SERVICE	
		9	10	11	12	13	14	15	16	17	18	
55.30	Implantable Devices Charged to Patients							713,162		234,375		55.30
56	Drugs Charged to Patients								4,617,268	711,755		56
57	Renal Dialysis		8,403							8,826		57
58	ASAC (Non-Distinct Part)											58
59 30	Other Ancillary Cost Centers		18,956		41,465		77,447			83,409		59 30
	OUTPATIENT SERVICE COST CENTERS											
60 05	Clinic				31,013					25,292		60 05
61	Emergency		154,438		106,980		301,724			202,256		61
62.00	Observation Beds											62 00
63.00	Other Outpatient Service (specify)											63.00
	OTHER REIMBURSABLE COST CENTERS											
64	Home Program Dialysis											64
65	Ambulance Services		119,455		163,734					68,265		65
66 00	Durable Medical Equipment-Rented											66 00
67.00	Durable Medical Equipment-Sold											67.00
68	Other Reimbursable (specify)											68
69 00	Outpatient Rehabilitation Provider (specify)											69 00
70	Intern-Resident Service (not apprvd. tchng. prgm.)											70
71	Home Health Agency											71
	SPECIAL PURPOSE COST CENTERS											
82	Lung Acquisition											82
83	Kidney Acquisition											83
84	Liver Acquisition											84
85.00	Heart Acquisition											85 00
86	Other Organ Acquisition (specify)											86
92	Ambulatory Surgical Center (Distinct Part)											92
93	Hospice											93
94	Other Special Purpose (specify)											94
95	SUBTOTALS (sum of lines 1-94)	1,667,060	3,146,405	1,811,664	1,770,866		2,986,555	2,400.411	4,617,268	4,606,719		95
	NONREIMBURSABLE COST CENTERS											

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COST ALLOCATION - GENERAL SERVICE COSTS					PROVIDER NO.: 420002		PERIOD: FROM 06/01/2009 TO 05/31/2010		WORKSHEET B. PART I			
COST CENTER DESCRIPTIONS		LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	MAIN-TENANCE OF PERSONNEL	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & MEDICAL LIBRARY	SOCIAL SERVICE	
		9	10	11	12	13	14	15	16	17	18	
96	Gift, Flower, Coffee Shop, &Canteen		8,452									96
97	Research											97
98	Physicians' Private Offices		1,933									98
99	Nonpaid Workers											99
100	Other Nonreimbursable (specify)		6,440		7,739					6,589		100
101	Cross Foot Adjustments											101
102	Negative Cost Centers											102
103	Total (sum of lines 95-102)	1,667,060	3,163,230	1,811,664	1,778,605		2,986,555	2,400,411	4,617,268	4,613,308		103

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PIEDMONT MEDICAL CENTER - ROCK HILL, SC
Cost report status - As Submitted
[Record code 274727 - 1996]

COST ALLOCATION - GENERAL SERVICE COSTS						PROVIDER NO.: 420002		PERIOD: FROM 06/01/2009 TO 05/31/2010		WORKSHEET B, PART I	
	COST CENTER DESCRIPTIONS	OTHER GENERAL SERVICE	NON-PHYSICIAN ANES-THETISTS	NURSING SCHOOL	INTERNS & RESIDENTS SALARY & FRINGES	INTERNS & RESIDENTS PROGRAM COSTS	PARA-MEDICAL EDUCATION (SPECIFY)	SUBTOTAL	INTERN & RESIDENT COST &POST STEPDOWN ADJUSTMENTS	TOTAL	
		19	20	21	22	23	24	25	26	27	
	GENERAL SERVICE COST CENTERS										
1	Old Capital Related Costs-Buildings and Fixtures										1
2	Old Capital Related Costs-Movable Equipment										2
3	New Capital Related Costs-Buildings and Fixtures										3
4	New Capital Related Costs-Movable Equipment										4
5	Employee Benefits										5
6.05	Administrative & General										6.05
7	Maintenance and Repairs										7
8	Operation of Plant										8
9	Laundry and Linen Service										9
10	Housekeeping										10
11	Dietary										11
12	Cafeteria										12
13	Maintenance of Personnel										13
14	Nursing Administration										14
15	Central Services and Supply										15
16	Pharmacy										16
17	Medical Records and Medical Records Library										17
18	Social Service										18
19.00	Other General Service (specify)										19.00
20	Nonphysician Anesthetists										20
21	Nursing School										21
22	Intern &Res. Service-Salary &Fringes (Approved)										22
23	Intern &Res. Other Program Costs (Approved)										23
24	Paramedical Ed. Program (specify)										24
	INPATIENT ROUTINE SERVICE COST CENTERS										
25	Adults and Pediatrics (General Routine Care)							41,733,926		41,733,926	25
26	Intensive Care Unit							8,200,554		8,200,554	26

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COST ALLOCATION - GENERAL SERVICE COSTS						PROVIDER NO.: 420002		PERIOD: FROM 06/01/2009 TO 05/31/2010		WORKSHEET B. PART I	
COST CENTER DESCRIPTIONS		OTHER GENERAL SERVICE	NON-PHYSICIAN ANES-THETISTS	NURSING SCHOOL	INTERNS & RESIDENTS SALARY & FRINGES	INTERNS & RESIDENTS PROGRAM COSTS	PARA-MEDICAL EDUCATION (SPECIFY)	SUBTOTAL	INTERN & RESIDENT COST &POST STEPDOWN ADJUSTMENTS	TOTAL	
		19	20	21	22	23	24	25	26	27	
27	Coronary Care Unit										27
28	Burn Intensive Care Unit										28
29	Surgical Intensive Care Unit										29
30.00	Other Special Care (specify)										30.00
31.00	SubComponent 1 - 42S002							3,309,969		3,309,969	31.00
33	Nursery							3,414,559		3,414,559	33
34	Skilled Nursery Facility										34
35.00	Nursing Facility										35.00
36	Other Long Term Care										36
	ANCILLARY SERVICE COST CENTERS										
37.05	Operating Room							14,701,201		14,701,201	37.05
38	Recovery Room										38
39.05	Delivery Room & Labor Room							4,199,409		4,199,409	39.05
40.00	Anesthesiology										40.00
41.05	Radiology-Diagnostic							9,753,127		9,753,127	41.05
42.00	Radiology-Therapeutic										42.00
43	Radioisotope										43
44.05	Laboratory							11,286,406		11,286,406	44.05
44.45	Vascular Lab							4,239,178		4,239,178	44.45
45	PBP Clinical Laboratory Services-Program Only										45
46.00	Whole Blood & Packed Red Blood Cells										46.00
47	Blood Storing, Processing, & Trans.										47
48	Intravenous Therapy							3,714,480		3,714,480	48
49.05	Respiratory Therapy							3,106,667		3,106,667	49.05
50.05	Physical Therapy							1,186,750		1,186,750	50.05
51	Occupational Therapy							169,097		169,097	51
52	Speech Pathology							187,693		187,693	52
53.05	Electrocardiology							1,329,109		1,329,109	53.05
54	Electroencephalography							784,722		784,722	54
55	Medical Supplies Charged to Patients							17,144,225		17,144,225	55

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COST ALLOCATION - GENERAL SERVICE COSTS						PROVIDER NO.: 420002		PERIOD: FROM 06/01/2009 TO 05/31/2010		WORKSHEET B. PART I	
COST CENTER DESCRIPTIONS		OTHER GENERAL SERVICE	NON-PHYSICIAN ANES-THETISTS	NURSING SCHOOL	INTERNS & RESIDENTS SALARY & FRINGES	INTERNS & RESIDENTS PROGRAM COSTS	PARA-MEDICAL EDUCATION (SPECIFY)	SUBTOTAL	INTERN & RESIDENT COST &POST STEPDOWN ADJUSTMENTS	TOTAL	
		19	20	21	22	23	24	25	26	27	
55.30	Implantable Devices Charged to Patients							16,344,142		16,344,142	55.30
56	Drugs Charged to Patients							15,190,145		15,190,145	56
57	Renal Dialysis							643,755		643,755	57
58	ASAC (Non-Distinct Part)										58
59.30	Other Ancillary Cost Centers							3,386,604		3,386,604	59.30
	OUTPATIENT SERVICE COST CENTERS										
60 05	Clinic							1,465,833		1,465,833	60.05
61	Emergency							8,753,162		8,753,162	61
62 00	Observation Beds										62.00
63.00	Other Outpatient Service (specify)										63.00
	OTHER REIMBURSABLE COST CENTERS										
64	Home Program Dialysis										64
65	Ambulance Services							11,424,859		11,424,859	65
66 00	Durable Medical Equipment-Rented										66 00
67.00	Durable Medical Equipment-Sold										67.00
68	Other Reimbursable (specify)										68
69 00	Outpatient Rehabilitation Provider (specify)										69.00
70	Intern-Resident Service (not apprvd. tchng. prgm.)										70
71	Home Health Agency										71
	SPECIAL PURPOSE COST CENTERS										
82	Lung Acquisition										82
83	Kidney Acquisition										83
84	Liver Acquisition										84
85 00	Heart Acquisition										85.00
86	Other Organ Acquisition (specify)										86
92	Ambulatory Surgical Center (Distinct Part)										92
93	Hospice										93
94	Other Special Purpose (specify)										94
95	SUBTOTALS (sum of lines 1-94)							185,669,572		185,669,572	95
	NONREIMBURSABLE COST CENTERS										

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COST ALLOCATION - GENERAL SERVICE COSTS						PROVIDER NO.: 420002		PERIOD: FROM 06/01/2009 TO 05/31/2010		WORKSHEET B. PART I	
COST CENTER DESCRIPTIONS		OTHER GENERAL SERVICE	NON-PHYSICIAN ANES-THETISTS	NURSING SCHOOL	INTERNS & RESIDENTS SALARY & FRINGES	INTERNS & RESIDENTS PROGRAM COSTS	PARA-MEDICAL EDUCATION (SPECIFY)	SUBTOTAL	INTERN & RESIDENT COST &POST STEPDOWN ADJUSTMENTS	TOTAL	
		19	20	21	22	23	24	25	26	27	
96	Gift, Flower, Coffee Shop, &Canteen							51,332		51,332	96
97	Research										97
98	Physicians' Private Offices							11,741		11,741	98
99	Nonpaid Workers										99
100	Other Nonreimbursable (specify)							2,840,442		2,840,442	100
101	Cross Foot Adjustments										101
102	Negative Cost Centers										102
103	Total (sum of lines 95-102)							188,573,087		188,573,087	103

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PIEDMONT MEDICAL CENTER - ROCK HILL, SC
Cost report status - As Submitted
[Record code 274727 - 1996]

COST ALLOCATION - STATISTICAL BASIS	PROVIDER NO. 420002	PERIOD. FROM 06/01/2009 TO 05/31/2010	WORKSHEET B-1

	COST CENTER DESCRIPTIONS	Old Capital Related Cost		New Capital Related Cost							
		Bldgs. & Fixtures (SQ FT)	Movable Equipment (Dollar Value)	Bldgs & Fixtures (SQ FT)	Movable Equipment (Dollar Value)	Employee benefits (gross salaries)	Reconcil-iation	Administrative & General (accum cost)	Maintenance & Repairs (Sq. Ft)	Operation of Plant (Sq Ft)	
		1	2	3	4	5	6A	6	7	8	
	GENERAL SERVICE COST CENTERS										1
1	Old Capital Related Costs-Buildings and Fixtures	468,313									2
2	Old Capital Related Costs-Movable Equipment		498,498								3
3	New Capital Related Costs-Buildings and Fixtures			468,313							4
4	New Capital Related Costs-Movable Equipment				498,498						5
5	Employee Benefits	6,178	6,178	6,178	6,178	62,673,656		140,161,168			6 05
6 05	Administrative & General	28,604	28,604	28,604	28,604	5,845,034					7
7	Maintenance and Repairs										8
8	Operation of Plant	105,282	105,282	105,282	105,282	666,552		9,187,271		328,249	9
9	Laundry and Linen Service	5,693	5,693	5,693	5,693			1,079,738		5,692	10
10	Housekeeping	1,825	1,825	1,825	1,825			2,300,061		1,824	11
11	Dietary	13,984	13,984	13,984	13,984			852,653		13,983	12
12	Cafeteria							1,321,986			13
13	Maintenance of Personnel										14
14	Nursing Administration	4,864	4,864	4,864	4,864	1,459,425		2,013,676		4,863	15
15	Central Services and Supply	12,497	12,497	12,497	12,497	468,999		1,331,734		12,496	16
16	Pharmacy	4,064	4,064	4,064	4,064	2,514,018		3,229,170		4,063	17
17	Medical Records & Medical Records Library	2,342	2,342	2,342	2,342	1,522,034		3,310,397		2,342	18
18	Social Service										19.00
19.00	Other General Service (specify)										20
20	Nonphysician Anesthetists										21
21	Nursing School										22
22	Intern & Res. Service-Salary & Fringes (Approved)										23
23	Intern & Res. Other Program Costs (Approved)										24
24	Paramedical Education Program (specify)										25
	INPATIENT ROUTINE SERVICE COST CENTERS	105,351	105,351	105,351	105,351	15,887,775		23,517,370		105,351	26
25	Adults and Pediatrics (General Routine Care)	17,776	17,776	17,776	17,776	3,493,655		4,886,179		17,775	
26	Intensive Care Unit										

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COST ALLOCATION - STATISTICAL BASIS						PROVIDER NO. 420002		PERIOD: FROM 06/01/2009 TO 05/31/2010		WORKSHEET B-1	
COST CENTER DESCRIPTIONS		Old Capital Related Cost		New Capital Related Cost							
		Bldgs. & Fixtures (SQ FT)	Movable Equipment (Dollar Value)	Bldgs & Fixtures (SQ FT)	Movable Equipment (Dollar Value)	Employee benefits (gross salaries)	Reconcil-iation	Administrative & General (accum cost)	Maintenance & Repairs (Sq. Ft)	Operation of Plant (Sq Ft)	
		1	2	3	4	5	6A	6	7	8	
27	Coronary Care Unit										27
28	Burn Intensive Care Unit										28
29	Surgical Intensive Care Unit										29
30 00	Other Special Care (specify)										30.00
31.00	SubComponent 1 - 42S002	9,677	9,677	9,677	9,677	1,241,661		1,810,934		9,676	31 00
33	Nursery	14,288	14,288	14,288	14,288	1,028,797		1,700,234		14,288	33
34	Skilled Nursing Facility										34
35.00	Nursing Facility										35.00
36	Other Long Term Care										36
	ANCILLARY SERVICE COST CENTERS										
37.05	Operating Room	40,826	40,826	40,826	40,826	5,629,131		8,775,616		40,825	37.05
38	Recovery Room										38
39.05	Delivery Room & Labor Room	13,613	13,613	13,613	13,613	1,644,935		2,465,514		13,613	39.05
40.00	Anesthesiology										40.00
41 05	Radiology-Diagnostic	17,011	18,341	17,011	18,341	3,362,244		6,187,396		17,010	41.05
42.00	Radiology-Therapeutic										42.00
43	Radioisotope										43
44.05	Laboratory	8,882	8,882	8,882	8,882	2,509,497		7,706,120		8,882	44.05
44 45	Vascular Lab	12,028	12,028	12,028	12,028	1,293,860		2,412,495		12,028	44.45
45	PBP Clinical Laboratory Services-Program Only										45
46.00	Whole Blood & Packed Red Blood Cells										46.00
47	Blood Storing, Processing, & Trans										47
48	Intravenous Therapy	5,613	5,613	5,613	5,613	109,186		2,370,955		5,613	48
49.05	Respiratory Therapy	3,041	3,041	3,041	3,041	1,498,480		2,097,269		3,040	49.05
50.05	Physical Therapy	1,263	1,263	1,263	1,263	519,565		808,606		1,263	50 05
51	Occupational Therapy					99,346		120,491			51
52	Speech Pathology					109,604		133,840			52
53.05	Electrocardiology	1,221	1,221	1,221	1,221	609,414		862,062		1,220	53.05
54	Electroencephalography	139	2,921	139	2,921	79,287		563,538		138	54
55	Medical Supplies Charged to Patients							11,076,552			55

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COST ALLOCATION - STATISTICAL BASIS						PROVIDER NO 420002		PERIOD: FROM 06/01/2009 TO 05/31/2010		WORKSHEET B-1	
COST CENTER DESCRIPTIONS		Old Capital Related Cost		New Capital Related Cost							
		Bldgs. & Fixtures (SQ FT)	Movable Equipment (Dollar Value)	Bldgs. & Fixtures (SQ FT)	Movable Equipment (Dollar Value)	Employee benefits (gross salaries)	Reconcil-iation	Administrative & General (accum cost)	Maintenance & Repairs (Sq. Ft)	Operation of Plant (Sq Ft)	
		1	2	3	4	5	6A	6	7	8	
55.30	Implantable Devices Charged to Patients							11,443,862			55.30
56	Drugs Charged to Patients							7,329,493			56
57	Renal Dialysis	852	852	852	852			441,831		851	57
58	ASC (Non-Distinct Part)										58
59.30	Other Ancillary Cost Centers	1,922	14,128	1,922	14,128	1,309,319		2,298,904		1,921	59.30
	OUTPATIENT SERVICE COST CENTERS										
60.05	Clinic		7,597		7,597	979,256		1,047,662			60.05
61	Emergency	15,659	15,659	15,659	15,659	3,378,048		5,498,803		15,658	61
62.00	Observation Beds										62.00
63.00	Other Outpatient Service (specify)										63.00
	OTHER REIMBURSABLE COST CENTERS										
64	Home Program Dialysis										64
65	Ambulance Services	12,112	19,435	12,112	19,435	5,170,162		7,891,550		12,112	65
66.00	Durable Medical Equipment-Rented										66.00
67.00	Durable Medical Equipment-Sold										67.00
68	Other Reimbursable (specify)										68
69.00	Outpatient Rehabilitation Provider (specify)										69.00
70	Intern-Resident Service (not appvd tchng. prgm.)										70
71	Home Health Agency										71
	SPECIAL PURPOSE COST CENTERS										
82	Lung Acquisition										82
83	Kidney Acquisition										83
84	Liver Acquisition										84
85.00	Heart Acquisition										85.00
86	Other Organ Acquisition (specify)										86
92	Ambulatory Surgical Center (Distinct Part)										92
93	Hospice										93
94	Other Special Purpose (specify)										94
95	SUBTOTALS (sum of lines 1-94)	466,607	497,845	466,607	497,845	62,429,300		138,073,984		326,543	95
	NONREIMBURSABLE COST CENTERS										

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COST ALLOCATION - STATISTICAL BASIS						PROVIDER NO. 420002		PERIOD FROM 06/01/2009 TO 05/31/2010		WORKSHEET B-1	
COST CENTER DESCRIPTIONS		Old Capital Related Cost		New Capital Related Cost							
		Bldgs. & Fixtures (SQ FT)	Movable Equipment (Dollar Value)	Bldgs. & Fixtures (SQ FT)	Movable Equipment (Dollar Value)	Employee benefits (gross salaries)	Reconcil-iation	Administrative & General (accum cost)	Maintenance & Repairs (Sq. Ft)	Operation of Plant (Sq Ft)	
		1	2	3	4	5	6A	6	7	8	
96	Gift, Flower, Coffee Shop, & Canteen	857		857				7,886		856	96
97	Research										97
98	Physicians' Private Offices	196		196				1,803		196	98
99	Nonpaid Workers										99
100	Other Nonreimbursable (specify)	653	653	653	653	244,357		2,077,507		651	100
101	Cross foot adjustments										101
102	Negative cost centers										102
103	Cost to be allocated (per Wkst. B, Part I)	875,811	336,257	3,432,576	6,628,360	1,649,696		48,412,088		12,360,581	103
104	Unit cost multiplier (Wkst. B, Part I)	1.870140	0.674540	7.329662	13.296663	0.026322		0.345403		37.656113	104
105	Cost to be allocated (per Wkst. B, Part II)										105
106	Unit cost multiplier (Wkst. B, Part II)										106
107	Cost to be allocated (per Wkst. B, Part III)										107
108	Unit cost multiplier (Wkst. B, Part III)										108

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PIEDMONT MEDICAL CENTER - ROCK HILL, SC
Cost report status - As Submitted
[Record code 274727 - 1996]

COST ALLOCATION - STATISTICAL BASIS						PROVIDER NO.420002		PERIOD. FROM 06/01/2009 TO 05/31/2010		WORKSHEET B-1		
	COST CENTER DESCRIPTIONS	Laundry & Linen Service (LB of Laundry)	Housekeeping (HRs of Service)	Dietary (Meals Served)	Cafeteria (Meals Served)	Maintenance of Personnel (Number Housed)	Nursing Admin ((Direct Nursing Hrs)	Central Services & Supply (Costed Req)	Pharmacy (Costed Req)	Medical Records & Libry (Time Spent)	Social Service (Time Spent)	
		9	10	11	12	13	14	15	16	17	18	
	GENERAL SERVICE COST CENTERS											
1	Old Capital Related Costs-Buildings and Fixtures											1
2	Old Capital Related Costs-Movable Equipment											2
3	New Capital Related Costs-Buildings and Fixtures											3
4	New Capital Related Costs-Movable Equipment											4
5	Employee Benefits											5
6.05	Administrative & General											6.05
7	Maintenance and Repairs											7
8	Operation of Plant											8
9	Laundry and Linen Service	65,117										9
10	Housekeeping		320,731									10
11	Dietary		13,983	65,117								11
12	Cafeteria				56,162,340							12
13	Maintenance of Personnel											13
14	Nursing Administration		4,864		1,459,408		22,609,316					14
15	Central Services and Supply		12,496		469,007			10,000				15
16	Pharmacy		4,063		2,514,036				100			16
17	Medical Records & Medical Records Library		2,341		1,522,024					585,073,984		17
18	Social Service											18
19.00	Other General Service (specify)											19.00
20	Nonphysician Anesthetists											20
21	Nursing School											21
22	Intern & Res. Service-Salary & Fringes (Approved)											22
23	Intern & Res. Other Program Costs (Approved)											23
24	Paramedical Education Program (specify)											24
	INPATIENT ROUTINE SERVICE COST CENTERS											
25	Adults and Pediatrics (General Routine Care)	50,518	105,351	50,518	15,887,999		10,787,682			58,415,476		25
26	Intensive Care Unit	5,357	17,776	5,358	3,493,669		2,154,042			12,753,964		26

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COST ALLOCATION - STATISTICAL BASIS						PROVIDER NO.420002		PERIOD: FROM 06/01/2009 TO 05/31/2010		WORKSHEET B-1		
	COST CENTER DESCRIPTIONS	Laundry & Linen Service (LB of Laundry)	Housekeeping (HRs of Service)	Dietary (Meals Served)	Cafeteria (Meals Served)	Maintenance of Personnel (Number Housed)	Nursing Admin ((Direct Nursing Hrs)	Central Services & Supply (Costed Req)	Pharmacy (Costed Req)	Medical Records & Libry (Time Spent)	Social Service (Time Spent)	
		9	10	11	12	13	14	15	16	17	18	
27	Coronary Care Unit											27
28	Burn Intensive Care Unit											28
29	Surgical Intensive Care Unit											29
30.00	Other Special Care (specify)											30.00
31.00	SubComponent 1 - 42S002	3,936	9,676	3,935	1,241,656		944,562			4,987,825		31.00
33	Nursery	5,304	14,287	5,303	1,028,797		783,457			3,638,173		33
34	Skilled Nursing Facility											34
35.00	Nursing Facility											35.00
36	Other Long Term Care											36
	ANCILLARY SERVICE COST CENTERS											
37.05	Operating Room		40,825		5,629,133		3,084,894			46,759,420		37.05
38	Recovery Room											38
39.05	Delivery Room & Labor Room		13,612		1,644,921		960,338			7,162,714		39.05
40.00	Anesthesiology											40.00
41.05	Radiology-Diagnostic		17,010		3,362,247		147,599			62,684,848		41.05
42.00	Radiology-Therapeutic											42.00
43	Radioisotope											43
44.05	Laboratory		8,881		2,509,489					52,889,664		44.05
44.45	Vascular Lab		12,028		1,293,852		683,664			36,849,844		44.45
45	PBP Clinical Laboratory Services-Program Only											45
46.00	Whole Blood & Packed Red Blood Cells											46.00
47	Blood Storing, Processing, & Trans.											47
48	Intravenous Therapy		5,613		109,191		57,860			31,295,626		48
49.05	Respiratory Therapy		3,040		1,498,468		59,851			10,796,449		49.05
50.05	Physical Therapy		1,262		519,561					2,838,047		50.05
51	Occupational Therapy				99,340					487,254		51
52	Speech Pathology				109,602					526,569		52
53.05	Electrocardiology		1,220		609,428		74,341			10,418,136		53.05
54	Electroencephalography		139		79,288		560			2,199,873		54
55	Medical Supplies Charged to Patients							7,029		70,329,872		55

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COST ALLOCATION - STATISTICAL BASIS						PROVIDER NO.420002		PERIOD: FROM 06/01/2009 TO 05/31/2010		WORKSHEET B-1		
COST CENTER DESCRIPTIONS		Laundry & Linen Service (LB of Laundry)	Housekeeping (HRs of Service)	Dietary (Meals Served)	Cafeteria (Meals Served)	Maintenance of Personnel (Number Housed)	Nursing Admin ((Direct Nursing Hrs)	Central Services & Supply (Costed Req)	Pharmacy (Costed Req)	Medical Records & Libry (Time Spent)	Social Service (Time Spent)	
		9	10	11	12	13	14	15	16	17	18	
55.30	Implantable Devices Charged to Patients							2,970		29,724,160		55.30
56	Drugs Charged to Patients								100	90,266,968		56
57	Renal Dialysis		852							1,119,340		57
58	ASC (Non-Distinct Part)											58
59.30	Other Ancillary Cost Centers		1,921		1,309,322		586,300			10,578,184		59.30
	OUTPATIENT SERVICE COST CENTERS											
60 05	Clinic				979,285					3,207,609		60.05
61	Emergency		15,659		3,378,067		2,284,161			25,650,730		61
62.00	Observation Beds											62.00
63.00	Other Outpatient Service (specify)											63.00
	OTHER REIMBURSABLE COST CENTERS											
64	Home Program Dialysis											64
65	Ambulance Services		12,111		5,170,166					8,657,578		65
66 00	Durable Medical Equipment-Rented											66.00
67.												67.
68	Other Reimbursable (specify)											68
69 00	Outpatient Rehabilitation Provider (specify)											69.00
70	Intern-Resident Service (not appvd. tchng. prgm.)											70
71	Home Health Agency											71
	SPECIAL PURPOSE COST CENTERS											
82	Lung Acquisition											82
83	Kidney Acquisition											83
84	Liver Acquisition											84
85 00	Heart Acquisition											85.00
86	Other Organ Acquisition (specify)											86
92	Ambulatory Surgical Center (Distinct Part)											92
93	Hospice											93
94	Other Special Purpose (specify)											94
95	SUBTOTALS (sum of lines 1-94)	65,117	319,025	65,117	55,917,968		22,609,316	10,000	100	584,238,336		95
	NONREIMBURSABLE COST CENTERS											

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COST ALLOCATION - STATISTICAL BASIS						PROVIDER NO.420002		PERIOD: FROM 06/01/2009 TO 05/31/2010		WORKSHEET B-1		
COST CENTER DESCRIPTIONS		Laundry & Linen Service (LB of Laundry)	Housekeeping (HRs of Service)	Dietary (Meals Served)	Cafeteria (Meals Served)	Maintenance of Personnel (Number Housed)	Nursing Admin ((Direct Nursing Hrs)	Central Services & Supply (Costed Req)	Pharmacy (Costed Req)	Medical Records & Libry (Time Spent)	Social Service (Time Spent)	
		9	10	11	12	13	14	15	16	17	18	
96	Gift, Flower, Coffee Shop, & Canteen		856									96
97	Research											97
98	Physicians' Private Offices		195									98
99	Nonpaid Workers											99
100	Other Nonreimbursable (specify)		651		244,370					835,637		100
101	Cross foot adjustments											101
102	Negative cost centers											102
103	Cost to be allocated (per Wkst B, Part I)	1,667,060	3,163,230	1,811,664	1,778,605		2,986,555	2,400,411	4,617,268	4,613,308		103
104	Unit cost multiplier (Wkst. B, Part I)	25.600994	9.862564	27.821674	0.031669		0.132094	240.041107	46,172.68	0 007885		104
105	Cost to be allocated (per Wkst. B, Part II)											105
106	Unit cost multiplier (Wkst. B, Part II)											106
107	Cost to be allocated (per Wkst B, Part III)											107
108	Unit cost multiplier (Wkst. B, Part III)											108

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PIEDMONT MEDICAL CENTER - ROCK HILL, SC
Cost report status - As Submitted
[Record code 274727 - 1996]

COST ALLOCATION - STATISTICAL BASIS					PROVIDER NO. 420002		PERIOD: FROM 06/01/2009 TO 05/31/2010		WORKSHEET B-1		
	COST CENTER DESCRIPTIONS	Other General Service (Specify)	Non-Physician Anesthetists (Assigned Time)	Nursing School (Assigned time)	Salary and Fringes (Assigned Time)	Program Costs (Assigned Time)	Paramedical Educ. Program (Assigned Time)	Subtotal	Intern & Resident Cost and Post Stepdown Adjustment	Total	
		19	20	21	22	23	24	25	26	27	
	GENERAL SERVICE COST CENTERS										
1	Old Capital Related Costs-Buildings and Fixtures										1
2	Old Capital Related Costs-Movable Equipment										2
3	New Capital Related Costs-Buildings and Fixtures										3
4	New Capital Related Costs-Movable Equipment										4
5	Employee Benefits										5
6 05	Administrative & General										6.05
7	Maintenance and Repairs										7
8	Operation of Plant										8
9	Laundry and Linen Service										9
10	Housekeeping										10
11	Dietary										11
12	Cafeteria										12
13	Maintenance of Personnel										13
14	Nursing Administration										14
15	Central Services and Supply										15
16	Pharmacy										16
17	Medical Records & Medical Records Library										17
18	Social Service										18
19.00	Other General Service (specify)										19.00
20	Nonphysician Anesthetists										20
21	Nursing School										21
22	Intern & Res. Service-Salary & Fringes (Approved)										22
23	Intern & Res. Other Program Costs (Approved)										23
24	Paramedical Education Program (specify)										24
	INPATIENT ROUTINE SERVICE COST CENTERS										
25	Adults and Pediatrics (General Routine Care)										25
26	Intensive Care Unit										26

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COST ALLOCATION - STATISTICAL BASIS					PROVIDER NO. 420002		PERIOD: FROM 06/01/2009 TO 05/31/2010		WORKSHEET B-1		
COST CENTER DESCRIPTIONS		Other General Service (Specify)	Non-Physician Anesthetists (Assigned time)	Nursing School (Assigned time)	Salary and Fringes (Assigned Time)	Program Costs (Assigned Time)	Paramedical Educ. Program (Assigned Time)	Subtotal	Intern & Resident Cost and Post Stepdown Adjustment	Total	
		19	20	21	22	23	24	25	26	27	
27	Coronary Care Unit										27
28	Burn Intensive Care Unit										28
29	Surgical Intensive Care Unit										29
30 00	Other Special Care (specify)										30 00
31.00	SubComponent 1 - 42S002										31.00
33	Nursery										33
34	Skilled Nursing Facility										34
35 00	Nursing Facility										35.00
36	Other Long Term Care										36
	ANCILLARY SERVICE COST CENTERS										
37.05	Operating Room										37.05
38	Recovery Room										38
39 05	Delivery Room & Labor Room										39 05
40 00	Anesthesiology										40 00
41.05	Radiology-Diagnostic										41.05
42 00	Radiology-Therapeutic										42.00
43	Radioisotope										43
44.05	Laboratory										44.05
44.45	Vascular Lab										44.45
45	PBP Clinical Laboratory Services-Program Only										45
46 00	Whole Blood & Packed Red Blood Cells										46 00
47	Blood Storing, Processing, & Trans.										47
48	Intravenous Therapy										48
49 05	Respiratory Therapy										49 05
50 05	Physical Therapy										50 05
51	Occupational Therapy										51
52	Speech Pathology										52
53 05	Electrocardiology										53.05
54	Electroencephalography										54
55	Medical Supplies Charged to Patients										55

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COST ALLOCATION - STATISTICAL BASIS					PROVIDER NO. 420002		PERIOD: FROM 06/01/2009 TO 05/31/2010		WORKSHEET B-1		
COST CENTER DESCRIPTIONS		Other General Service (Specify)	Non-Physician Anesthetists (Assigned Time)	Nursing School (Assigned time)	Salary and Fringes (Assigned Time)	Program Costs (Assigned Time)	Paramedical Educ. Program (Assigned Time)	Subtotal	Intern & Resident Cost and Post Stepdown Adjustment	Total	
		19	20	21	22	23	24	25	26	27	
55.30	Implantable Devices Charged to Patients										55.30
56	Drugs Charged to Patients										56
57	Renal Dialysis										57
58	ASC (Non-Distinct Part)										58
59.30	Other Ancillary Cost Centers										59.30
	OUTPATIENT SERVICE COST CENTERS										
60.05	Clinic										60.05
61	Emergency										61
62.00	Observation Beds										62.00
63.00	Other Outpatient Service (specify)										63.00
	OTHER REIMBURSABLE COST CENTERS										
64	Home Program Dialysis										64
65	Ambulance Services										65
66.00	Durable Medical Equipment-Rented										66.00
67.00	Durable Medical Equipment-Sold										67.00
68	Other Reimbursable (specify)										68
69.00	Outpatient Rehabilitation Provider (specify)										69.00
70	Intern-Resident Service (not appvd. tchng. prgm.)										70
71	Home Health Agency										71
	SPECIAL PURPOSE COST CENTERS										
82	Lung Acquisition										82
83	Kidney Acquisition										83
84	Liver Acquisition										84
85.00	Heart Acquisition										85.00
86	Other Organ Acquisition (specify)										86
92	Ambulatory Surgical Center (Distinct Part)										92
93	Hospice										93
94	Other Special Purpose (specify)										94
95	SUBTOTALS (sum of lines 1-94)										95
	NONREIMBURSABLE COST CENTERS										

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COST ALLOCATION - STATISTICAL BASIS					PROVIDER NO. 420002		PERIOD: FROM 06/01/2009 TO 05/31/2010		WORKSHEET B-1		
COST CENTER DESCRIPTIONS		Other General Service (Specify)	Non-Physician Anesthetista (Assigned Time)	Nursing School (Assigned time)	Salary and Fringes (Assigned Time)	Program Costs (Assigned Time)	Paramedical Educ. Program (Assigned Time)	Subtotal	Intern & Resident Cost and Post Stepdown Adjustment	Total	
		19	20	21	22	23	24	25	26	27	
96	Gift, Flower, Coffee Shop, & Canteen										96
97	Research										97
98	Physicians' Private Offices										98
99	Nonpaid Workers										99
100	Other Nonreimbursable (specify)										100
101	Cross foot adjustments										101
102	Negative cost centers										102
103	Cost to be allocated (per Wkst B, Part I)										103
104	Unit cost multiplier (Wkst. B, Part I)										104
105	Cost to be allocated (per Wkst. B, Part II)										105
106	Unit cost multiplier (Wkst. B, Part II)										106
107	Cost to be allocated (per Wkst B, Part III)										107
108	Unit cost multiplier (Wkst. B, Part III)										108

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PIEDMONT MEDICAL CENTER - ROCK HILL, SC
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COMPUTATION OF RATIO OF COSTS TO CHARGES			PROVIDER NO: 420002					PERIOD: FROM 06/01/2009 TO 05/31/2010			WORKSHEET C, PART I	
	COST CENTER DESCRIPTIONS	Total Cost from Wkst B,Part I col 27	Therapy Limit Adj.	Total Costs	RCE Dis-allowance	Total Costs	Inpatient Charges	Outpatient Charges	Total Charges (col 6 + col 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		1	2	3	4	5	6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS												
25	Adults and Pediatrics (General Routine Care)	41,733,926		41,733,926	3,747	41,737,673	54,560,245		54,560,245				25
26	Intensive Care Unit	8,200,554		8,200,554	8,666	8,209,220	12,754,020		12,754,020				26
27	Coronary Care Unit												27
28	Burn Intensive Care Unit												28
29	Surgical Intensive Care Unit												29
30.00	Other Special Care (specify)												30.00
31.00	SubComponent 1 - 42S002	3,309,969		3,309,969	8,552	3,318,521	4,987,875		4,987,875				31.00
33	Nursery	3,414,559		3,414,559		3,414,559	3,638,160		3,638,160				33
34	Skilled Nursing Facility												34
35.00	Nursing Facility												35.00
36	Other Long Term Care												36
	ANCILLARY SERVICE COST CENTERS												
37.05	Operating Room	14,701,201		14,701,201		14,701,201	25,611,433	21,274,437	46,885,870	0.313553	0.313553	0.313553	37.05
38	Recovery Room												38
39.05	Delivery Room & Labor Room	4,199,409		4,199,409		4,199,409	6,792,929	361,761	7,154,690	0.586945	0.586945	0.586945	39.05
40.00	Anesthesiology												40.00
41.05	Radiology-Diagnostic	9,753,127		9,753,127		9,753,127	15,462,397	48,199,894	63,662,291	0.153201	0.153201	0.153201	41.05
42.00	Radiology-Therapeutic												42.00
43	Radioisotope												43
44.05	Laboratory	11,286,406		11,286,406		11,286,406	32,794,013	19,931,830	52,725,843	0.214058	0.214058	0.214058	44.05
44.45	Vascular Lab	4,239,178		4,239,178		4,239,178	17,335,118	19,645,242	36,980,360	0.114633	0.114633	0.114633	44.45
45	PBP Clinical Laboratory Services-Prgm. Only												45
46.00	Whole Blood & Packed Red Blood Cells												46.00
47	Blood Storing, Processing, & Trans.												47
48	Intravenous Therapy	3,714,480		3,714,480		3,714,480	23,420,482	7,875,103	31,295,585	0.118690	0.118690	0.118690	48
49.05	Respiratory Therapy	3,106,667		3,106,667		3,106,667	9,710,540	1,127,952	10,838,492	0.286633	0.286633	0.286633	49.05
50.05	Physical Therapy	1,186,750		1,186,750		1,186,750	2,116,554	749,615	2,866,169	0.414054	0.414054	0.414054	50.05
51	Occupational Therapy	169,097		169,097		169,097	269,952	220,901	490,853	0.344496	0.344496	0.344496	51

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COMPUTATION OF RATIO OF COSTS TO CHARGES						PROVIDER NO: 420002			PERIOD: FROM 06/01/2009 TO 05/31/2010			WORKSHEET C, PART I	
	COST CENTER DESCRIPTIONS	Total Cost from Wkst B,Part I col 27	Therapy Limit Adj	Total Costs	RCE Dis-allowance	Total Costs	Inpatient Charges	Outpatient Charges	Total Charges (col 6 + col 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		1	2	3	4	5	6	7	8	9	10	11	
52	Speech Pathology	187,693		187,693		187,693	366,330	165,807	532,137	0 352716	0 352716	0.352716	52
53 05	Electrocardiology	1,329,109		1,329,109		1,329,109	7,024,717	3,393,365	10,418,082	0 127577	0.127577	0.127577	53.05
54	Electroencephalography	784,722		784,722		784,722	542,325	1,657,543	2,199,868	0.356713	0.356713	0.356713	54
55	Medical Supplies Charged to Patients	17,144,225		17,144,225		17,144,225	38,745,370	28,226,823	66,972,193	0.255990	0.255990	0.255990	55
55.30	Implantable Devices Charged to Patients	16,344,142		16,344,142		16,344,142	18,838,284	10,885,845	29,724,129	0.549861	0.549861	0.549861	55.30
56	Drugs Charged to Patients	15,190,145		15,190,145		15,190,145	68,088,695	22,170,983	90,259,678	0.168294	0 168294	0.168294	56
57	Renal Dialysis	643,755		643,755		643,755	1,080,346	39,009	1,119,355	0.575112	0.575112	0.575112	57
58	ASC (Non-Distinct Part)												58
59.30	Other Ancillary Cost Centers	3,386,604		3,386,604	6,222	3,392,826	3,076,646	7,619,812	10,696,458	0.316610	0.316610	0.317192	59.30
OUTPATIENT SERVICE COST CENTERS													
60.05	Clinic	1,465,833		1,465,833		1,465,833	8,150	3,199,446	3,207,596	0.456988	0.456988	0.456988	60.05
61	Emergency	8,753,162		8,753,162	396	8,753,558	4,847,480	20,803,217	25,650,697	0.341245	0.341245	0.341260	61
62 10	Observation Beds (Non-DistinctPart)	1,556,539		1,556,539		1,556,539	1,080,575	2,774,620	3,855,195	0 403751	0 403751	0.403751	62.10
63.00	Other Outpatient Service (specify)												63.00
OTHER REIMBURSABLE COST CENTERS													
64	Home Program Dialysis												64
65	Ambulance Services	11,424,859		11,424,859		11,424,859	600,721	8,047,614	8,648,335	1.321047	1.321047	1.321047	65
66.00	Durable Medical Equipment-Rented												66.00
67.00	Durable Medical Equipment-Sold												67.00
68	Other Reimbursable (specify)												68
101	Subtotal (sum of lines 25 thru 68)	187,226,111		187,226,111	27,583	187,253,694	353,753,357	228,370,819	582,124,176				101
102	Less Observation Beds	1,556,539		1,556,539		1,556,539							102
103	Total (line 101 minus line 102)	185,669,572		185,669,572	27,583	185,697,155	353,753,357	228,370,819	582,124,176				103

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PIEDMONT MEDICAL CENTER - ROCK HILL, SC
Cost report status - As Submitted
[Record code 274727 - 1996]

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS						PROVIDER NO. 420002		PERIOD: FROM 06/01/2009 TO 05/31/2010		WORKSHEET C, PART II	
	Cost Center Descriptions	Total Cost (Wkst. B, Part I, col. 27)	Capital Cost (Wkst. B, sum of Parts II & III, col. 27)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	Cost Net of Capital and Operating Cost Reduction	Total Charges (Wkst. C, Part I, col. 8)	Outpatient Cost to Charge Ratio (col. 6 ÷ col. 7)	I/P Part B Cost to Charge Ratio (see instruc.)	
		1	2	3	4	5	6	7	8	9	
	ANCILLARY SERVICE COST CENTERS										
37.05	Operating Room	14,701,201	14,701,201					46,885,870		0.313553	37.05
38	Recovery Room										38
39.05	Delivery Room & Labor Room	4,199,409	4,199,409					7,154,690		0.586945	39.05
40.00	Anesthesiology										40.00
41.05	Radiology-Diagnostic	9,753,127	9,753,127					63,662,291		0.153201	41.05
42.00	Radiology-Therapeutic										42.00
43	Radioisotope										43
44.05	Laboratory	11,286,406	11,286,406					52,725,843		0.214058	44.05
44.45	Vascular Lab	4,239,178	4,239,178					36,980,360		0.114633	44.45
45	PBP Clinical Laboratory Services-Prgm Only										45
46.00	Whole Blood & Packed Red Blood Cells										46.00
47	Blood Storing, Processing, & Trans.										47
48	Intravenous Therapy	3,714,480	3,714,480					31,295,585		0.118690	48
49.05	Respiratory Therapy	3,106,667	3,106,667					10,838,492		0.286633	49.05
50.05	Physical Therapy	1,186,750	1,186,750					2,866,169		0.414054	50.05
51	Occupational Therapy	169,097	169,097					490,853		0.344496	51
52	Speech Pathology	187,693	187,693					532,137		0.352716	52
53.05	Electrocardiology	1,329,109	1,329,109					10,418,082		0.127577	53.05
54	Electroencephalography	784,722	784,722					2,199,868		0.356713	54
55	Medical Supplies Charged to Patients	17,144,225	17,144,225					66,972,193		0.255990	55
56	Drugs Charged to Patients	15,190,145	15,190,145					90,259,678		0.168294	56
57	Renal Dialysis	643,755	643,755					1,119,355		0.575112	57
58	ASC (Non-Distinct Part)										58
59.30	Other Ancillary Cost Centers	3,386,604	3,386,604					10,696,458		0.316610	59.30
60.05	Clinic	1,465,833	1,465,833					3,207,596		0.456988	60.05
61	Emergency	8,753,162	8,753,162					25,650,697		0.341245	61
62.10	Observation Beds (Non-DistinctPart)							3,855,195			62.10
63.00	Other Outpatient Service (specify)										63.00

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CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS						PROVIDER NO. 420002		PERIOD: FROM 06/01/2009 TO 05/31/2010		WORKSHEET C, PART II	
	Cost Center Descriptions	Total Cost (Wkst. B, Part I, col. 27)	Capital Cost (Wkst. B, sum of Parts II & III, col. 27)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	Cost Net of Capital and Operating Cost Reduction	Total Charges (Wkst. C, Part I, col. 8)	Outpatient Cost to Charge Ratio (col. 6 ÷ col. 7)	I/P Part B Cost to Charge Ratio (see instruc.)	
		1	2	3	4	5	6	7	8	9	
	OTHER REIMBURSABLE COST CENTERS										
64	Home Program Dialysis										64
65	Ambulance Services	11,424,859	11,424,859					8,648,335		1.321047	65
66	Durable Medical Equipment - Rented										66
67	Durable Medical Equipment - Sold										67
68	Other Reimbursable (specify)										68
101	Subtotal (sum of lines 37-68)							582,124,176			101
102	Less Observation Beds										102
103	Total (sum of line 101 minus line 102)	188,573,087						582,124,176			103

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PIEDMONT MEDICAL CENTER - ROCK HILL, SC
Cost report status - As Submitted
[Record code 274727 - 1996]

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS	PROVIDER NO. 420002	PERIOD. FROM 06/01/2009 TO: 05/31/2010	WORKSHEET D, PART I

Medicare - Title XVIII - Hospital - 420002

	Cost Center Description	Old Capital			New Capital			Total Patient Days	Inpatient Program Days	Old Capital		New Capital		
		Capital Related Cost (from Wkst. B, Part II, col. 27)	Swing Bed Adj.	Reduced Capital Related Cost (col. 1 - col. 2)	Capital Related Cost (from Wkst. B, Part III, col. 27)	Swing Bed Adj.	Reduced Capital Related Cost (col. 4 - col. 5)			Per Diem (col. 3 ÷ col. 7)	Inpatient Program Capital Cost (col. 9 x col. 8)	Per Diem (col. 6 ÷ col. 7)	Inpatient Program Capital Cost (col. 11 x col. 8)	
		1	2	3	4	5	6	7	8	9	10	11	12	
(A)	INPATIENT ROUTINE SERVICE COST CENTERS													
25	Adults & Pediatrics (General Routine Care)	436,900		436,900	3,905,282		3,905,282	52,476	25,662	8.33	213,764	74.42	1,909,766	25
26	Intensive Care Unit	71,440		71,440	650,664		650,664	5,358	3,125	13.33	41,656	121.44	379,500	26
27	Coronary Care Unit													27
28	Burn Intensive Care Unit													28
29	Surgical Intensive Care Unit													29
30.00	Other Special Care (specify)													30.00
31.00	SubComponent 1 - 42S002	39,115		39,115	346,135		346,135	3,936	1,222	9.94	12,147	87.94	107,463	31.00
33	Nursery	55,946		55,946	483,129		483,129	5,304		10.55		91.09		33
101	Total (lines 25-33)	603,401		603,401	5,385,210		5,385,210	67,074	30,009		267,567		2,396,729	101

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PIEDMONT MEDICAL CENTER - ROCK HILL, SC
Cost report status - As Submitted
[Record code 274727 - 1996]

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS	PROVIDER NO. 420002	PERIOD: FROM: 06/01/2009 TO: 05/31/2010	WORKSHEET D, PART I

Medicaid - Title XIX - Hospital - 420002

	Cost Center Description	Old Capital			New Capital					Old Capital		New Capital		
		Capital Related Cost (from Wkst. B, Part II, col. 27)	Swing Bed Adj.	Reduced Capital Related Cost (col. 1 - col. 2)	Capital Related Cost (from Wkst. B, Part III, col. 27)	Swing Bed Adj.	Reduced Capital Related Cost (col. 4 - col. 5)	Total Patient Days	Inpatient Program Days	Per Diem (col 3 ÷ col. 7)	Inpatient Program Capital Cost (col. 9 x col. 8)	Per Diem (col. 6 ÷ col. 7)	Inpatient Program Capital Cost (col. 11 x col. 8)	
		1	2	3	4	5	6	7	8	9	10	11	12	
(A)	INPATIENT ROUTINE SERVICE COST CENTERS													
25	Adults & Pediatrics (General Routine Care)	436,900		436,900	3,905,282		3,905,282	52,476	8,115	8.33	67,598	74.42	603,918	25
26	Intensive Care Unit	71,440		71,440	650,664		650,664	5,358	809	13.33	10,784	121.44	98,245	26
27	Coronary Care Unit													27
28	Burn Intensive Care Unit													28
29	Surgical Intensive Care Unit													29
30.00	Other Special Care (specify)													30.00
31.00	SubComponent 1 - 42S002	39,115		39,115	346,135		346,135	3,936	856	9.94	8,509	87.94	75,277	31.00
33	Nursery	55,946		55,946	483,129		483,129	5,304	2,564	10.55	27,050	91.09	233,555	33
101	Total (lines 25-33)	603,401		603,401	5,385,210		5,385,210	67,074	12,344		113,941		1,010,995	101

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PIEDMONT MEDICAL CENTER - ROCK HILL, SC
Cost report status - As Submitted
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	PROVIDER NO: 420002	PERIOD: FROM: 06/01/2009 TO: 05/31/2010	WORKSHEET D, PART II

Medicare -Title XVIII - Hospital - 420002

	Cost Center Description	Old Capital Related Cost (from Wkst. B, Part II, col. 27)	New Capital Related Cost (from Wkst. B, Part III, col. 27)	Total Charges (from Wkst. C, Part I, col. 8)	Inpatient Program Charges	Old Capital: Ratio of Cost to Charges (col. 1 ÷ col. 3)	Old Capital: Capital Costs (col. 4 x col. 5)	New Capital: Ratio of Cost to Charges (col. 2 ÷ col. 3)	New Capital: Capital Costs (col. 4 x col. 7)	
		1	2	3	4	5	6	7	8	
(A)	ANCILLARY SERVICE COST CENTERS									
37.05	Operating Room	148,156	1,332,393	46,885,870	10,470,482	0.003160	33,087	0.028418	297,550	37.05
38	Recovery Room									38
39.05	Delivery Room & Labor Room	48,898	433,059	7,154,690	13,388	0.006834	91	0.060528	810	39.05
40.00	Anesthesiology									40.00
41.05	Radiology-Diagnostic	64,067	677,547	63,662,291	7,655,567	0.001006	7,702	0.010643	81,478	41.05
42.00	Radiology-Therapeutic									42.00
43	Radioisotope									43
44.05	Laboratory	35,835	395,754	52,725,843	16,140,631	0.000680	10,976	0.007506	121,152	44.05
44.45	Vascular Lab	43,675	398,742	36,980,360	8,004,489	0.001181	9,453	0.010783	86,312	44.45
45	PBP Clinical Laboratory Services-Prgm. Only									45
46.00	Whole Blood & Packed Red Blood Cells									46.00
47	Blood Storing, Processing, & Transfusing									47
48	Intravenous Therapy	20,942	204,400	31,295,585	10,352,354	0.000669	6,926	0.006531	67,611	48
49.05	Respiratory Therapy	12,075	127,240	10,838,492	5,446,969	0.001114	6,068	0.011740	63,947	49.05
50.05	Physical Therapy	4,906	50,215	2,866,169	1,305,559	0.001712	2,235	0.017520	22,873	50.05
51	Occupational Therapy	98	2,292	490,853	158,113	0.000200	32	0.004669	738	51
52	Speech Pathology	109	2,540	532,137	264,231	0.000205	54	0.004773	1,261	52
53.05	Electrocardiology	5,003	52,887	10,418,082	3,880,680	0.000480	1,863	0.005076	19,698	53.05
54	Electroencephalography	2,706	103,210	2,199,868	301,733	0.001230	371	0.046916	14,156	54
55	Medical Supplies Charged to Patients	37,510	457,437	66,972,193	15,634,377	0.000560	8,755	0.006830	106,783	55
55.30	Implantable Devices Charged to Patients		300,540	29,724,129	10,196,803		6,669	0.010111	103,100	55.30
56	Drugs Charged to Patients	21,775	313,692	90,259,678	32,430,137	0.000241	7,816	0.003475	112,695	56
57	Renal Dialysis	3,149	31,155	1,119,355	832,029	0.002813	2,340	0.027833	23,158	57
58	ASC (Non-Distinct Part)									58
59.30	Other Ancillary Cost Centers	16,975	550,847	10,696,458	1,425,604	0.001587	1,021	0.051498	10,425	59.30
60.05	Clinic	5,992	266,190	3,207,596	4,342	0.001868	8	0.082987	358	60.05

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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	PROVIDER NO: 420002	PERIOD: FROM: 06/01/2009 TO: 05/31/2010	WORKSHEET D, PART II

Medicare - Title XVIII - Hospital - 420002

	Cost Center Description	Old Capital Related Cost (from Wkst. B, Part II, col 27)	New Capital Related Cost (from Wkst. B, Part III, col. 27)	Total Charges (from Wkst. C, Part I, col 8)	Inpatient Program Charges	Old Capital - Ratio of Cost to Charges (col. 1 ÷ col. 3)	Old Capital - Capital Costs (col 4 x col 5)	New Capital - Ratio of Cost to Charges (col. 2 ÷ col. 3)	New Capital - Capital Costs (col. 4 x col. 7)	
		1	2	3	4	5	6	7	8	
61	Emergency	59,284	557,982	25,650,697	2,255,865	0.002311	5,213	0.021753	49,072	61
62.10	Observation Beds (Non-DistinctPart)	16,294	145,641	3,855,195	529,486	0.004227	2,238	0.037778	20,003	62.10
63.00	Other Outpatient Service (specify)									63.00
	OTHER REIMBURSABLE COST CENTERS									
64	Home Program Dialysis									64
65	Ambulance Services									65
66.00	Durable Medical Equipment-Rented									66 00
67.00	Durable Medical Equipment-Sold									67 00
68	Other Reimbursable (specify)									68
101	Total (sum of lines 37 through 68)	566,886	6,403,763	497,535,541	127,302,839		112,918		1,203,180	101

(A) Worksheet A line numbers

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PIEDMONT MEDICAL CENTER - ROCK HILL, SC
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	PROVIDER NO: 420002	PERIOD: FROM: 06/01/2009 TO: 05/31/2010	WORKSHEET D, PART II

Medicare -Title XVIII - Subprovider 1 - 42S002

		Old Capital Related Cost (from Wkst. B, Part II, col. 27)	New Capital Related Cost (from Wkst. B, Part III, col. 27)	Total Charges (from Wkst. C, Part I, col. 8)	Inpatient Program Charges	Old Capital		New Capital		
						Ratio of Cost to Charges (col. 1 ÷ col. 3)	Capital Costs (col. 4 x col. 5)	Ratio of Cost to Charges (col. 2 ÷ col. 3)	Capital Costs (col. 4 x col. 7)	
Cost Center Description		1	2	3	4	5	6	7	8	
(A)	ANCILLARY SERVICE COST CENTERS									
37.05	Operating Room	148,156	1,332,393	46,885,870	26,207	0.003160	83	0.028418	745	37.05
38	Recovery Room									38
39.05	Delivery Room & Labor Room	48,898	433,059	7,154,690		0.006834		0 060528		39.05
40 00	Anesthesiology									40.00
41 05	Radiology-Diagnostic	64,067	677,547	63,662,291	35,615	0.001006	36	0.010643	379	41 05
42.00	Radiology-Therapeutic									42.00
43	Radioisotope									43
44 05	Laboratory	35,835	395,754	52,725,843	124,969	0.000680	85	0 007506	938	44 05
44.45	Vascular Lab	43,675	398.742	36,980,360		0.001181		0.010783		44.45
45	PBP Clinical Laboratory Services-Prgm. Only									45
46 00	Whole Blood & Packed Red Blood Cells									46.00
47	Blood Storing, Processing, & Transfusing									47
48	Intravenous Therapy	20,942	204.400	31,295,585	4,713	0.000669	3	0.006531	31	48
49.05	Respiratory Therapy	12,075	127,240	10,838,492	8,700	0.001114	10	0.011740	102	49.05
50 05	Physical Therapy	4,906	50,215	2,866,169	2,439	0.001712	4	0 017520	43	50 05
51	Occupational Therapy	98	2,292	490,853	351	0.000200		0 004669	2	51
52	Speech Pathology	109	2,540	532,137	253	0.000205		0.004773	1	52
53.05	Electrocardiology	5,003	52,887	10,418,082	8,978	0.000480	4	0.005076	46	53.05
54	Electroencephalography	2,706	103,210	2,199,868	845	0.001230	1	0 046916	40	54
55	Medical Supplies Charged to Patients	37,510	457,437	66,972,193	9,345	0.000560	5	0.006830	64	55
55 30	Implantable Devices Charged to Patients		300,540	29,724,129				0 010111		55.30
56	Drugs Charged to Patients	21,775	313,692	90,259,678	520,368	0.000241	125	0.003475	1,808	56
57	Renal Dialysis	3,149	31,155	1,119,355	3,013	0.002813	8	0.027833	84	57
58	ASC (Non-Distinct Part)									58
59 30	Other Ancillary Cost Centers	16,975	550,847	10,696,458	61,124	0.001587	13	0.051498	300	59.30
60 05	Clinic	5,992	266,190	3,207,596		0.001868		0.082987		60.05

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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	PROVIDER NO: 420002	PERIOD: FROM: 06/01/2009 TO: 05/31/2010	WORKSHEET D, PART II

Medicare -Title XVIII - Subprovider 1 - 42S002

	Cost Center Description	Old Capital Related Cost (from Wkst. B, Part II, col. 27)	New Capital Related Cost (from Wkst. B, Part III, col. 27)	Total Charges (from Wkst. C, Part I, col. 8)	Inpatient Program Charges	Old Capital		New Capital		
						Ratio of Cost to Charges (col 1 ÷ col. 3)	Capital Costs (col. 4 x col. 5)	Ratio of Cost to Charges (col. 2 ÷ col 3)	Capital Costs (col. 4 x col. 7)	
		1	2	3	4	5	6	7	8	
61	Emergency	59,284	557,982	25,650,697	64,616	0.002311	149	0.021753	1,406	61
62.10	Observation Beds (Non-DistinctPart)			3,855,195						62.10
63.00	Other Outpatient Service (specify)									63.00
	OTHER REIMBURSABLE COST CENTERS									
64	Home Program Dialysis									64
65	Ambulance Services									65
66.00	Durable Medical Equipment-Rented									66.00
67.00	Durable Medical Equipment-Sold									67.00
68	Other Reimbursable (specify)									68
101	Total (sum of lines 37 through 68)	550,592	6,258,122	497,535,541	871,536		525		5,989	101

(A) Worksheet A line numbers

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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	PROVIDER NO: 420002	PERIOD: FROM: 06/01/2009 TO: 05/31/2010	WORKSHEET D, PART II

Medicaid - Title XIX - Hospital - 420002

		Old Capital Related Cost (from Wkst. B, Part II, col. 27)	New Capital Related Cost (from Wkst. B, Part III, col. 27)	Total Charges (from Wkst. C, Part I, col. 8)	Inpatient Program Charges	Old Capital		New Capital		
						Ratio of Cost to Charges (col. 1 ÷ col. 3)	Capital Costs (col. 4 x col. 5)	Ratio of Cost to Charges (col. 2 ÷ col. 3)	Capital Costs (col. 4 x col. 7)	
Cost Center Description		1	2	3	4	5	6	7	8	
(A)	ANCILLARY SERVICE COST CENTERS									
37.05	Operatng Room	148,156	1,332,393	46,885,870	1,475,215	0.003160	4,662	0.028418	41,923	37.05
38	Recovery Room									38
39 05	Delivery Room & Labor Room	48,898	433,059	7,154,690	2,100,994	0.006834	14,358	0.060528	127,169	39.05
40.00	Anesthesiology									40 00
41.05	Radiology-Diagnostic	64,067	677,547	63,662,291	1,049,322	0 001006	1,056	0 010643	11,168	41.05
42.00	Radiology-Therapeutic									42.00
43	Radioisotope									43
44 05	Laboratory	35,835	395,754	52,725,843	2,590,742	0 000680	1,762	0 007506	19,446	44 05
44.45	Vascular Lab	43,675	398,742	36,980,360	586,605	0.001181	693	0.010783	6,325	44.45
45	PBP Clinical Laboratory Services-Prgm. Only									45
46.00	Whole Blood & Packed Red Blood Cells									46.00
47	Blood Storing, Processing, & Transfusing									47
48	Intravenous Therapy	20,942	204,400	31,295,585	2,501,023	0.000669	1,673	0.006531	16,334	48
49.05	Respiratory Therapy	12,075	127,240	10,838,492	1,087,911	0.001114	1,212	0.011740	12,772	49.05
50 05	Physical Therapy	4,906	50,215	2,866,169	126,628	0 001712	217	0 017520	2,219	50 05
51	Occupational Therapy	98	2,292	490,853	25,975	0.000200	5	0 004669	121	51
52	Speech Pathology	109	2,540	532,137	29,408	0.000205	6	0 004773	140	52
53.05	Electrocardiology	5,003	52,887	10,418,082	376,563	0.000480	181	0.005076	1,911	53.05
54	Electroencephalography	2,706	103,210	2,199,868	44,697	0 001230	55	0 046916	2,097	54
55	Medical Supplies Charged to Patients	37,510	457,437	66,972,193	3,316,311	0.000560	1,857	0.006830	22,650	55
55 30	Implantable Devices Charged to Patients		300,540	29,724,129	517,763		339	0.010111	5,235	55.30
56	Drugs Charged to Patients	21,775	313,692	90,259,678	6,735,292	0.000241	1,623	0.003475	23,405	56
57	Renal Dialysis	3,149	31,155	1,119,355	61,465	0.002813	173	0.027833	1,711	57
58	ASC (Non-Distinct Part)									58
59.30	Other Ancillary Cost Centers	16,975	550,847	10,696,458	239,520	0.001587	131	0.051498	1,439	59.30
60.05	Clinic	5,992	266,190	3,207,596		0.001868		0.082987		60.05

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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	PROVIDER NO: 420002	PERIOD: FROM: 06/01/2009 TO: 05/31/2010	WORKSHEET D, PART II

Medicaid - Title XIX - Hospital - 420002

	Cost Center Description	Old Capital Related Cost (from Wkst. B, Part II, col. 27)	New Capital Related Cost (from Wkst. B, Part III, col. 27)	Total Charges (from Wkst. C, Part I, col 8)	Inpatient Program Charges	Old Capital: Ratio of Cost to Charges (col. 1 ÷ col. 3)	Old Capital: Capital Costs (col. 4 x col. 5)	New Capital: Ratio of Cost to Charges (col. 2 ÷ col. 3)	New Capital: Capital Costs (col. 4 x col 7)	
		1	2	3	4	5	6	7	8	
61	Emergency	59,284	557,982	25,650,697	362,492	0.002311	838	0.021753	7,885	61
62.10	Observation Beds (Non-DistinctPart)	16,294	145,641	3,855,195	84,832	0.004227	359	0.037778	3,205	62.10
63.00	Other Outpatient Service (specify)									63 00
	OTHER REIMBURSABLE COST CENTERS									
64	Home Program Dialysis									64
65	Ambulance Services									65
66.00	Durable Medical Equipment-Rented									66.00
67 00	Durable Medical Equipment-Sold									67.00
68	Other Reimbursable (specify)									68
101	Total (sum of lines 37 through 68)	566,886	6,403,763	497,535,541	23,312,758		31,200		307,155	101

(A) Worksheet A line numbers

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PIEDMONT MEDICAL CENTER - ROCK HILL, SC
Cost report status - As Submitted
[Record code 274727 - 1996]

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	PROVIDER NO: 420002	PERIOD: FROM: 06/01/2009 TO: 05/31/2010	WORKSHEET D, PART III

Medicare -Title XVIII - Hospital - 420002

	Cost Center Description	Nonphysician Anesthetist Cost	Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Tota Costs (sum of cols. 1 + 2, minus col. 3)	Total Patient Days	Per Diem (col. 4 ÷ col. 5)	Inpatient Program Days	Inpatient Program Pass thru Cost (col. 6 x col. 7)	
		1	2	3	4	5	6	7	8	
(A)	INPATIENT ROUTINE SERVICE COST CENTERS									
25	Adults & Pediatrics (General Routine Care)					52,476		25,662		25
26	Intensive Care Unit					5,358		3,125		26
27	Coronary Care Unit									27
28	Burn Intensive Care Unit									28
29	Surgical Intensive Care Unit									29
30.00	Other Special Care (specify)									30.00
31 00	SubComponent 1 - 42S002					3,936		1,222		31 00
33	Nursery					5,304				33
34	Skilled Nursing Facility									34
35 00	Nursing Facility									35.00
101	Total (sum of lines 25-35)					67,074		30,009		101

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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	PROVIDER NO: 420002	PERIOD: FROM: 06/01/2009 TO: 05/31/2010	WORKSHEET D, PART III

Medicaid - Title XIX - Hospital - 420002

	Cost Center Description	Nonphysician Anesthetist Cost	Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Tota Costs (sum of cols. 1 + 2, minus col. 3)	Total Patient Days	Per Diem (col. 4 + col. 5)	Inpatient Program Days	Inpatient Program Pass thru Cost (col 6 x col. 7)	
		1	2	3	4	5	6	7	8	
(A)	INPATIENT ROUTINE SERVICE COST CENTERS									
25	Adults & Pediatrics (General Routine Care)					52,476		8,115		25
26	Intensive Care Unit					5,358		809		26
27	Coronary Care Unit									27
28	Burn Intensive Care Unit									28
29	Surgical Intensive Care Unit									29
30.00	Other Special Care (specify)									30.00
31.00	SubComponent 1 - 42S002					3,936		856		31 00
33	Nursery					5,304		2,564		33
34	Skilled Nursing Facility									34
35.00	Nursing Facility									35 00
101	Total (sum of lines 25-35)					67,074		12,344		101

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PIEDMONT MEDICAL CENTER - ROCK HILL, SC
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	PROVIDER NO. 420002	PERIOD: FROM: 06/01/2009 TO: 05/31/2010	WORKSHEET D, PART IV

Medicare - Title XVIII - Hospital - 420002

	Cost Center Description	Nonphysician Anesthetist Cost	Medical Education Cost	Total Costs (col. 1 + col. 2)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 3 ÷ col. 4)	Inpatient Program Charges	Inpatient Program Pass Through Costs (col. 5 × col. 6)	Outpatient Program Charges	Outpatient Program Pass Through Costs (col. 5 × col. 8)	
		1	2	3	4	5	6	7	8	9	
(A)	ANCILLARY SERVICE COST CENTERS										
37.05	Operating Room				46,885,870		10,470,482		5,566,611		37.05
38	Recovery Room										38
39.05	Delivery Room & Labor Room				7,154,690		13,388		9,763		39.05
40.00	Anesthesiology										40.00
41.05	Radiology-Diagnostic				63,662,291		7,655,567		13,233,653		41.05
42.00	Radiology-Therapeutic										42.00
43	Radioisotope										43
44.05	Laboratory				52,725,843		16,140,631		5,498,535		44.05
44.45	Vascular Lab				36,980,360		8,004,489		8,530,421		44.45
45	PBP Clinical Laboratory Services-Prgm Only										45
46.00	Whole Blood & Packed Red Blood Cells										46.00
47	Blood Storing, Processing, & Transfusing										47
48	Intravenous Therapy				31,295,585		10,352,354		2,113,186		48
49.05	Respiratory Therapy				10,838,492		5,446,969		382,229		49.05
50.05	Physical Therapy				2,866,169		1,305,559				50.05
51	Occupational Therapy				490,853		158,113				51
52	Speech Pathology				532,137		264,231				52
53.05	Electrocardiology				10,418,082		3,880,680		1,161,143		53.05
54	Electroencephalography				2,199,868		301,733		377,901		54
55	Medical Supplies Charged to Patients				66,972,193		15,634,377		9,298,112		55
55.30	Implantable Devices Charged to Patients						10,196,803		4,921,539		55.30
56	Drugs Charged to Patients				90,259,678		32,430,137		7,403,246		56
57	Renal Dialysis				1,119,355		832,029				57
58	ASC (Non-Distinct Part)										58
59.30	Other Ancillary Cost Centers				10,696,458		1,425,604		2,989,519		59.30
	OUTPATIENT SERVICE COST CENTERS										
60.05	Clinic				3,207,596		4,342		903,104		60.05
61	Emergency				25,650,697		2,255,865		3,160,255		61
62.10	Observation Beds (Non-DistinctPart)				3,855,195		529,486		1,109,921		62.10
63.00	Other Outpatient Service (specify)										63.00
	OTHER REIMBURSABLE COST CENTERS										
64	Home Program Dialysis										64

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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS		PROVIDER NO: 420002	PERIOD: FROM: 06/01/2009 TO: 05/31/2010	WORKSHEET D, PART IV

Medicare -Title XVIII - Hospital - 420002

	Cost Center Description	Nonphysician Anesthetist Cost	Medical Education Cost	Total Costs (col. 1 + col. 2)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 3 ÷ col. 4)	Inpatient Program Charges	Inpatient Program Pass Through Costs (col. 5 × col. 6)	Outpatient Program Charges	Outpatient Program Pass Through Costs (col. 5 × col. 8)	
		1	2	3	4	5	6	7	8	9	
65	Ambulance Services										65
66 00	Durable Medical Equipment-Rented										66.00
67 00	Durable Medical Equipment-Sold										67.00
68	Other Reimbursable (specify)										68
101	Total (sum of lines 37 through 68)				467,811,412		127,302,839		66,659,138		101

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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	PROVIDER NO 420002	PERIOD. FROM: 06/01/2009 TO: 05/31/2010	WORKSHEET D, PART IV

Medicare - Title XVIII - Subprovider 1 - 42S002

	Cost Center Description	Nonphysician Anesthetist Cost	Medical Education Cost	Total Costs (col. 1 + col. 2)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 3 ÷ col. 4)	Inpatient Program Charges	Inpatient Program Pass Through Costs (col. 5 × col. 6)	Outpatient Program Charges	Outpatient Program Pass Through Costs (col. 5 × col. 8)	
		1	2	3	4	5	6	7	8	9	
(A)	ANCILLARY SERVICE COST CENTERS										
37.05	Operating Room				46,885,870		26,207				37.05
38	Recovery Room										38
39.05	Delivery Room & Labor Room				7,154,690						39.05
40.00	Anesthesiology										40.00
41.05	Radiology-Diagnostic				63,662,291		35,615				41.05
42.00	Radiology-Therapeutic										42.00
43	Radioisotope										43
44.05	Laboratory				52,725,843		124,969				44.05
44.45	Vascular Lab				36,980,360						44.45
45	PBP Clinical Laboratory Services-Prgm. Only										45
46.00	Whole Blood & Packed Red Blood Cells										46.00
47	Blood Storing, Processing, & Transfusing										47
48	Intravenous Therapy				31,295,585		4,713				48
49.05	Respiratory Therapy				10,838,492		8,700				49.05
50.05	Physical Therapy				2,866,169		2,439				50.05
51	Occupational Therapy				490,853		351				51
52	Speech Pathology				532,137		253				52
53.05	Electrocardiology				10,418,082		8,978				53.05
54	Electroencephalography				2,199,868		845				54
55	Medical Supplies Charged to Patients				66,972,193		9,345				55
55.30	Implantable Devices Charged to Patients										55.30
56	Drugs Charged to Patients				90,259,678		520,368		788		56
57	Renal Dialysis				1,119,355		3,013				57
58	ASC (Non-Distinct Part)										58
59.30	Other Ancillary Cost Centers				10,696,458		61,124				59.30
	OUTPATIENT SERVICE COST CENTERS										
60.05	Clinic				3,207,596						60.05
61	Emergency				25,650,697		64,616				61
62.10	Observation Beds (Non-DistinctPart)				3,855,195						62.10
63.00	Other Outpatient Service (specify)										63.00
	OTHER REIMBURSABLE COST CENTERS										
64	Home Program Dialysis										64

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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS		PROVIDER NO: 420002	PERIOD: FROM: 06/01/2009 TO: 05/31/2010	WORKSHEET D, PART IV

Medicare -Title XVIII - Subprovider 1 - 42S002

	Cost Center Description	Nonphysician Anesthetist Cost	Medical Education Cost	Total Costs (col. 1 + col. 2)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 3 ÷ col. 4)	Inpatient Program Charges	Inpatient Program Pass Through Costs (col. 5 × col. 6)	Outpatient Program Charges	Outpatient Program Pass Through Costs (col. 5 × col. 8)	
		1	2	3	4	5	6	7	8	9	
65	Ambulance Services										65
66.00	Durable Medical Equipment-Rented										66.00
67.00	Durable Medical Equipment-Sold										67.00
68	Other Reimbursable (specify)										68
101	Total (sum of lines 37 through 68)				467,811,412		871,536		788		101

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PIEDMONT MEDICAL CENTER - ROCK HILL, SC
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	PROVIDER NO: 420002	PERIOD: FROM: 06/01/2009 TO: 05/31/2010	WORKSHEET D, PART IV

Medicaid - Title XIX - Hospital - 420002

	Cost Center Description	Nonphysician Anesthetist Cost	Medical Education Cost	Total Costs (col. 1 + col. 2)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 3 ÷ col. 4)	Inpatient Program Charges	Inpatient Program Pass Through Costs (col. 5 × col. 6)	Outpatient Program Charges	Outpatient Program Pass Through Costs (col. 5 × col. 8)	
		1	2	3	4	5	6	7	8	9	
(A)	ANCILLARY SERVICE COST CENTERS										
37.05	Operating Room				46,885,870		1,475,215		1,410,515		37.05
38	Recovery Room										38
39.05	Delivery Room & Labor Room				7,154,690		2,100,994		103,453		39.05
40.00	Anesthesiology										40.00
41.05	Radiology-Diagnostic				63,662,291		1,049,322		2,694,606		41.05
42.00	Radiology-Therapeutic										42.00
43	Radioisotope										43
44.05	Laboratory				52,725,843		2,590,742		1,452,267		44.05
44.45	Vascular Lab				36,980,360		586,605		313,815		44.45
45	PBP Clinical Laboratory Services-Prgm. Only										45
46.00	Whole Blood & Packed Red Blood Cells										46.00
47	Blood Storing, Processing, & Transfusing										47
48	Intravenous Therapy				31,295,585		2,501,023		529,938		48
49.05	Respiratory Therapy				10,838,492		1,087,911		66,195		49.05
50.05	Physical Therapy				2,866,169		126,628		200,348		50.05
51	Occupational Therapy				490,853		25,975		36,489		51
52	Speech Pathology				532,137		29,408		13,554		52
53.05	Electrocardiology				10,418,082		376,563		152,025		53.05
54	Electroencephalography				2,199,868		44,697		106,863		54
55	Medical Supplies Charged to Patients				66,972,193		3,316,311		1,515,691		55
55.30	Implantable Devices Charged to Patients						517,763		216,998		55.30
56	Drugs Charged to Patients				90,259,678		6,735,292		1,098,303		56
57	Renal Dialysis				1,119,355		61,465				57
58	ASC (Non-Distinct Part)										58
59.30	Other Ancillary Cost Centers				10,696,458		239,520		378,115		59.30
	OUTPATIENT SERVICE COST CENTERS										
60.05	Clinic				3,207,596				63,307		60.05
61	Emergency				25,650,697		362,492		2,047,718		61
62.10	Observation Beds (Non-DistinctPart)				3,855,195		84,832		129,134		62.10
63.00	Other Outpatient Service (specify)										63.00
	OTHER REIMBURSABLE COST CENTERS										
64	Home Program Dialysis										64

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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS		PROVIDER NO: 420002	PERIOD: FROM: 06/01/2009 TO: 05/31/2010	WORKSHEET D, PART IV

Medicaid - Title XIX - Hospital - 420002

	Cost Center Description	Nonphysician Anesthetist Cost	Medical Education Cost	Total Costs (col. 1 + col. 2)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 3 ÷ col. 4)	Inpatient Program Charges	Inpatient Program Pass Through Costs (col. 5 × col. 6)	Outpatient Program Charges	Outpatient Program Pass Through Costs (col. 5 × col. 8)	
		1	2	3	4	5	6	7	8	9	
65	Ambulance Services										65
66.00	Durable Medical Equipment-Rented										66.00
67.00	Durable Medical Equipment-Sold										67.00
68	Other Reimbursable (specify)										68
101	Total (sum of lines 37 through 68)				467,811,412		23,312,758		12,529,334		101

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PIEDMONT MEDICAL CENTER - ROCK HILL, SC
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APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	PROVIDER NO: 420002	PERIOD: FROM 06/01/2009 TO 05/31/2010	WORKSHEET D, PARTS V & VI

Medicare - Title XVIII - Hospital - 420002

PART V - APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

Cost Center Description	Cost to Charge Ratio From Worksheet C			PROGRAM CHARGES						PROGRAM COSTS								
	Part II col. 8	Part I col. 9	Part II col. 9	Outpatient Ambulatory Surgical Center	Outpatient Radiology	Other Outpatient Diagnostic	All Other (1) (see instru.)	PPS services (see instru.)	All Other (see instru.)	Outpatient Ambulatory Surgical Center (cols. 1 × 2)	Outpatient Radiology (cols. 1 × 3)	Other Outpatient Diagnostic (cols. 1 × 4)	All Other (cols. 1 × 5)	PPS services (columns 1.01 × 5.01)	All Other (columns 1.01 × 5.02)	Hospital I/P Part B Charges (see instru.)	Hospital I/P part B Cost (columns 1.02 × 10)	
	1	1.01	1.02	2	3	4	5	5.01	5.02	6	7	8	9	9.01	9.02	10	11	
ANCILLARY SERVICE COST CENTERS																		
37.05 Operating Room		0.313553	0.313553					5,566,611	417					1,745,428	131			37.05
38 Recovery Room																		38
39.05 Delivery Room & Labor Room		0 586945	0 586945					9,763						5,730				39.05
40.00 Anesthesiology																		40.00
41.05 Radiology-Diagnostic		0.153201	0 153201					13,233,653	2,570					2,027,409	394			41.05
42.00 Radiology-Therapeutic																		42.00
43 Radioisotope																		43
44 05 Laboratory		0.214058	0.214058					5,498,535						1,177,005				44.05
44.45 Vascular Lab		0.114633	0.114633					8,530,421						977,868				44.45
45 PBP Clinic Laboratory Services-Prgm Only																		45
46.00 Whole Blood & Packed Red Blood Cells																		46.00
47 Blood Storing, Processing, & Transfusing																		47
48 Intravenous Therapy		0.118690	0.118690					2,113,186						250,814				48
49 05 Respiratory Therapy		0.286633	0.286633					382,229	898					109,559	257			49.05
50.05 Physical Therapy		0.414054	0.414054															50.05
51 Occupational Therapy		0.344496	0.344496															51
52 Speech Pathology		0.352716	0 352716															52
53.05 Electrocardiology		0.127577	0.127577					1,161,143						148,135				53.05
54 Electroencephalography		0.356713	0.356713					377,901						134,802				54
55 Medical Supplies Charged To Patients		0.255990	0 255990					9,298,112	124					2,380,224	32			55
55.30 Implantable Devices Charged to Patients								4,921,539						2,706,162				55.30
56 Drugs Charged To Patients		0.168294	0.168294					7,403,246						1,245,922				56
57 Renal Dialysis		0 575112	0 575112															57
58 ASC (Non-Distinct Part)																		58
59.30 Other Ancillary Cost Centers		0.316610	0.316610					2,989,519						1,119,932				59.30
OUTPATIENT SERVICE COST CENTERS																		

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APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	PROVIDER NO: 420002	PERIOD: FROM 06/01/2009 TO 05/31/2010	WORKSHEET D, PARTS V & VI

Medicare - Title XVIII - Hospital - 420002

PART V - APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

	Cost Center Description	Cost to Charge Ratio From Worksheet C			PROGRAM CHARGES						PROGRAM COSTS								
		Part II col. 8	Part I col. 9	Part II col. 9	Outpatient Ambulatory Surgical Center	Outpatient Radiology	Other Outpatient Diagnostic	All Other (1) (see instru.)	PPS services (see instru.)	All Other (see instru.)	Outpatient Ambulatory Surgical Center (cols 1 × 2)	Outpatient Radiology (cols. 1 × 3)	Other Outpatient Diagnostic (cols. 1 × 4)	All Other (cols 1 × 5)	PPS services (columns 1.01 × 5.01)	All Other (columns 1.01 × 5.02)	Hospital I/P Part B Charges (see instru.)	Hospital I/P part B Cost (columns 1 02 × 10)	
		1	1.01	1.02	2	3	4	5	5.01	5.02	6	7	8	9	9.01	9.02	10	11	
60.05	Clinic		0.456988	0.456988					903,104						403,641				60.05
61	Emergency		0.341245	0.341245					3,160,255						1,078,421				61
62.10	Observation Beds (Non-DistinctPart)		0.402751						1,109,921						448,132				62.10
63.00	Other Outpatient Service (specify)																		63.00
	OTHER REIMBURSABLE COST CENTERS																		
64	Home Program Dialysis																		64
65	Ambulance		1.321047	1.321047															65
66.00	Durable Medical Equipment-Rented																		66.00
67.00	Durable Medical Equipment-Sold																		67.00
68	Other Reimbursable Cost Center																		68
101	Subtotal (see instructions)								66,659,138	4,009					15,959,184	814			101
102	CRNA Charges (see instructions)																		102
103	Less PBP Clinic Lab Services-Program Only Charges																		103
104	Net Charges (line 101 + (lines 102 + 103)								66,659,138	4,009					15,959,184	814			104

PART VI - VACCINE COST APPORTIONMENT

		1	
1	Drugs charged to patients - ratio of cost to charges (from Worksheet C, Part I, column 9, line 56)		1
2	Program vaccine charges (from your records or the PS&R)	152,583	2
3	Program costs (line 1 × lines 2) (see instructions for transfer)	25,679	3
	(A) Worksheet A line numbers (1) Report non hospital and non subprovider components cost for the period here (see instructions)		

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Cost report status - As Submitted
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APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	PROVIDER NO 420002	PERIOD: FROM 06/01/2009 TO 05/31/2010	WORKSHEET D, PARTS V & VI

Medicare -Title XVIII - Subprovider 1 - 42S002

PART V - APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

	Cost Center Description	Cost to Charge Ratio From Worksheet C			PROGRAM CHARGES						PROGRAM COSTS								
		Part II col 8	Part I col. 9	Part II col. 9	Outpatient Ambulatory Surgical Center	Outpatient Radiology	Other Outpatient Diagnostic	All Other (1) (see instru.)	PPS services (see instru.)	All Other (see instru.)	Outpatient Ambulatory Surgical Center (cols 1 × 2)	Outpatient Radiology (cols. 1 × 3)	Other Outpatient Diagnostic (cols 1 × 4)	All Other (cols. 1 × 5)	PPS services (columns 1.01 × 5.01)	All Other (columns 1.01 × 5.02)	Hospital I/P Part B Charges (see instru.)	Hospital I/P part B Cost (columns 1 02 × 10)	
		1	1.01	1.02	2	3	4	5	5.01	5.02	6	7	8	9	9.01	9.02	10	11	
	ANCILLARY SERVICE COST CENTERS																		
37.05	Operating Room		0.313553	0.313553															37.05
38	Recovery Room																		38
39 05	Delivery Room & Labor Room		0.586945	0.586945															39.05
40.00	Anesthesiology																		40.00
41.05	Radiology-Diagnostic		0.153201	0 153201															41.05
42.00	Radiology-Therapeutic																		42.00
43	Radioisotope																		43
44.05	Laboratory		0.214058	0.214058															44.05
44 45	Vascular Lab		0.114633	0.114633															44.45
45	PBP Clinic Laboratory Services-Prgm Only																		45
46.00	Whole Blood & Packed Red Blood Cells																		46.00
47	Blood Storing, Processing, & Transfusing																		47
48	Intravenous Therapy		0.118690	0.118690															48
49.05	Respiratory Therapy		0 286633	0.286633															49.05
50.05	Physical Therapy		0.414054	0.414054															50.05
51	Occupational Therapy		0.344496	0 344496															51
52	Speech Pathology		0.352716	0 352716															52
53.05	Electrocardiology		0.127577	0.127577															53.05
54	Electroencephalography		0.356713	0 356713															54
55	Medical Supplies Charged To Patients		0.255990	0.255990															55
55 30	Implantable Devices Charged to Patients																		55.30
56	Drugs Charged To Patients		0.168294	0.168294					788						133				56
57	Renal Dialysis		0.575112	0 575112															57
58	ASC (Non-Distinct Part)																		58
59.30	Other Ancillary Cost Centers		0.316610	0.316610															59.30
	OUTPATIENT SERVICE COST CENTERS																		

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APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	PROVIDER NO: 420002	PERIOD: FROM 06/01/2009 TO 05/31/2010	WORKSHEET D, PARTS V & VI

Medicare -Title XVIII - Subprovider 1 - 42S002

PART V - APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

	Cost Center Description	Cost to Charge Ratio From Worksheet C			PROGRAM CHARGES						PROGRAM COSTS								
		Part II col. 8	Part I col. 9	Part II col. 9	Outpatient Ambulatory Surgical Center	Outpatient Radiology	Other Outpatient Diagnostic	All Other (1) (see instru.)	PPS services (see instru.)	All Other (see instru.)	Outpatient Ambulatory Surgical Center (cols. 1 × 2)	Outpatient Radiology (cols. 1 × 3)	Other Outpatient Diagnostic (cols. 1 × 4)	All Other (cols. 1 × 5)	PPS services (columns 1.01 × 5.01)	All Other (columns 1.01 × 5.02)	Hospital I/P Part B Charges (see instru.)	Hospital I/P part B Cost (columns 1.02 × 10)	
		1	1.01	1.02	2	3	4	5	5.01	5.02	6	7	8	9	9.01	9.02	10	11	
60.05	Clinic		0.456988	0.456988															60.05
61	Emergency		0.341245	0.341245															61
62.10	Observation Beds (Non-DistinctPart)		0.403751																62.10
63.00	Other Outpatient Service (specify)																		63.00
	OTHER REIMBURSABLE COST CENTERS																		
64	Home Program Dialysis																		64
65	Ambulance		1.321047	1.321047															65
66.00	Durable Medical Equipment-Rented																		66.00
67.00	Durable Medical Equipment-Sold																		67.00
68	Other Reimbursable Cost Center																		68
101	Subtotal (see instructions)								788						133				101
102	CRNA Charges (see instructions)																		102
103	Less PBP Clinic Lab. Services-Program Only Charges																		103
104	Net Charges (line 101 ± (lines 102 + 103)								788						133				104

PART VI - VACCINE COST APPORTIONMENT

		1	
1	Drugs charged to patients - ratio of cost to charges (from Worksheet C, Part I, column 9, line 56)		1
2	Program vaccine charges (from your records or the PS&R)	2,197	2
3	Program costs (line 1 × lines 2) (see instructions for transfer)	370	3

(A) Worksheet A line numbers
(1) Report non hospital and non subprovider components cost for the period here (see instructions)

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PIEDMONT MEDICAL CENTER - ROCK HILL, SC
Cost report status - As Submitted
[Record code 274727 - 1996]

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	PROVIDER NO: 420002	PERIOD: FROM 06/01/2009 TO 05/31/2010	WORKSHEET D, PARTS V & VI

Medicaid - Title XIX - Hospital - 420002

PART V - APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

	Cost Center Description	Cost to Charge Ratio From Worksheet C			PROGRAM CHARGES						PROGRAM COSTS								
		Part II col. 8	Part I col. 9	Part II col. 9	Outpatient Ambulatory Surgical Center	Outpatient Radiology	Other Outpatient Diagnostic	All Other (1) (see instru.)	PPS services (see instru.)	All Other (see instru.)	Outpatient Ambulatory Surgical Center (cols. 1 × 2)	Outpatient Radiology (cols. 1 × 3)	Other Outpatient Diagnostic (cols. 1 × 4)	All Other (cols. 1 × 5)	PPS services (columns 1.01 × 5.01)	All Other (columns 1.01 × 5.02)	Hospital I/P Part B Charges (see instru.)	Hospital I/P part B Cost (columns 1.02 × 10)	
		1	1.01	1.02	2	3	4	5	5.01	5.02	6	7	8	9	9.01	9.02	10	11	
	ANCILLARY SERVICE COST CENTERS																		
37.05	Operating Room		0.313553	0.313553				1,410,515						442,271					37.05
38	Recovery Room																		38
39.05	Delivery Room & Labor Room		0.586945	0.586945				103,453						60,721					39.05
40.00	Anesthesiology																		40.00
41.05	Radiology-Diagnostic		0.153201	0.153201				2,694,606						412,816					41.05
42.00	Radiology-Therapeutic																		42.00
43	Radioisotope																		43
44.05	Laboratory		0.214058	0.214058				1,452,267						310,869					44.05
44.45	Vascular Lab		0.114633	0.114633				313,815						35,974					44.45
45	PBP Clinic Laboratory Services-Prgm. Only																		45
46.00	Whole Blood & Packed Red Blood Cells																		46.00
47	Blood Storing, Processing, & Transfusing																		47
48	Intravenous Therapy		0.118690	0.118690				529,938						62,898					48
49.05	Respiratory Therapy		0.286633	0.286633				66,195						18,974					49.05
50.05	Physical Therapy		0.414054	0.414054				200,348						82,955					50.05
51	Occupational Therapy		0.344496	0.344496				36,489						12,570					51
52	Speech Pathology		0.352716	0.352716				13,554						4,781					52
53.05	Electrocardiology		0.127577	0.127577				152,025						19,395					53.05
54	Electroencephalography		0.356713	0.356713				106,863						38,119					54
55	Medical Supplies Charged To Patients		0.255990	0.255990				1,515,691						388,002					55
55.30	Implantable Devices Charged to Patients							216,998						119,319					55.30
56	Drugs Charged To Patients		0.168294	0.168294				1,098,303						184,838					56
57	Renal Dialysis		0.575112	0.575112															57
58	ASC (Non-Distinct Part)																		58
59.30	Other Ancillary Cost Centers		0.316610	0.316610				378,115						159,138					59.30
	OUTPATIENT SERVICE COST CENTERS																		

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APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST					PROVIDER NO: 420002		PERIOD: FROM 06/01/2009 TO 05/31/2010		WORKSHEET D, PARTS V & VI

Medicaid - Title XIX - Hospital - 420002

PART V - APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

	Cost Center Description	Cost to Charge Ratio From Worksheet C			PROGRAM CHARGES						PROGRAM COSTS								
		Part II col. 8	Part I col. 9	Part II col. 9	Outpatient Ambulatory Surgical Center	Outpatient Radiology	Other Outpatient Diagnostic	All Other (1) (see instru.)	PPS services (see instru.)	All Other (see instru.)	Outpatient Ambulatory Surgical Center (cols. 1 × 2)	Outpatient Radiology (cols. 1 × 3)	Other Outpatient Diagnostic (cols 1 × 4)	All Other (cols. 1 × 5)	PPS services (columns 1.01 × 5.01)	All Other (columns 1.01 × 5.02)	Hospital I/P Part B Charges (see instru.)	Hospital I/P part B Cost (columns 1.02 × 10)	
		1	1.01	1.02	2	3	4	5	5.01	5.02	6	7	8	9	9.01	9.02	10	11	
60.05	Clinic		0.456988	0.456988				63,307						28,295					60.05
61	Emergency		0.341245	0.341245				2,047,718						698,774					61
62.10	Observation Beds (Non-DistinctPart)		0.403751					129,134						52,138					62.10
63.00	Other Outpatient Service (specify)																		63.00
	OTHER REIMBURSABLE COST CENTERS																		
64	Home Program Dialysis																		64
65	Ambulance		1.321047	1.321047				514,195						[illegible]					65
66.00	Durable Medical Equipment-Rented																		66.00
67.00	Durable Medical Equipment-Sold																		67.00
68	Other Reimbursable Cost Center																		68
101	Subtotal (see instructions)							13,043,529						3,812,123					101
102	CRNA Charges (see instructions)																		102
103	Less PBP Clinic Lab. Services-Program Only Charges																		103
104	Net Charges (line 101 ± (lines 102 + 103)							13,043,529						3,812,123					104

PART VI - VACCINE COST APPORTIONMENT

		1	
1	Drugs charged to patients - ratio of cost to charges (from Worksheet C, Part I, column 9, line 56)		1
2	Program vaccine charges (from your records or the PS&R)		2
3	Program costs (line 1 × lines 2) (see instructions for transfer)		3
	(A) Worksheet A line numbers (1) Report non hospital and non subprovider components cost for the period here (see instructions)		

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PIEDMONT MEDICAL CENTER - ROCK HILL, SC
Cost report status - As Submitted
[Record code 274727 - 1996]

	COMPUTATION OF INPATIENT OPERATING COST	PROVIDER NO: 420002	PERIOD: FROM 06/01/2009 TO 05/31/2010	WORKSHEET D-1, PART I	
Medicare -Title XVIII - Hospital - 420002					
PART I - ALL PROVIDER COMPONENTS					
	INPATIENT DAYS				
1	Inpatient days (including private room days, and swing-bed days, excluding new born)			52,476	1
2	Inpatient days (including private room days, excluding swing-bed days and new born days)			52,476	2
3	Private room days (excluding swing-bed private room days)			31,810	3
4	Semi-private room days (excluding swing-bed private room days)			20,666	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period				5
6	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)				6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period				7
8	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)				8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and new born days)			25,662	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period				10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after Decmeber 31 of the cost reporting period				11
12	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				12
13	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)				13
14	Medically necessary private room days applicable to the Program (excluding swing-bed days)			13,025	14
15	Total nursery days				15
16	Title V or XIX nursery days				16
	SWING BED ADJUSTEMENT				
17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period				17
18	Medicare rate for swing-bed SNF services applicable to services after Decmeber 31 of the cost reporting period				18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period				19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period				20
21	Total general inpatient routine service cost (see instructions)			41,737,673	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 × line 17)				22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 × line 18)				23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 × line 18)				24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 × line 20)				25
26	Total swing-bed cost (sum of lines 22 through 25)				26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			41,737,673	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28	General inpatient routine service charges (excluding swing-bed charges)			54,560,245	28
29	Private room charges (excluding swing-bed charges)			24,435,990	29
30	Semi-private room charges (excluding swing-bed charges)			30,124,255	30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.764983	31
32	Average private room per diem charge (line 29 ÷ line 3)			768.19	32
33	Average semi-private room per diem charge (line 30 ÷ line 4)			1,457.67	33
34	Average per diem private room charge differential (line 32 minus line 33)				34
35	Average per diem private private room cost differential (line 34 × line 31)				35
36	Private room cost differential adjustment (line 3 × line 35)				36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			41,737,673	37

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Cost report status - As Submitted
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	COMPUTATION OF INPATIENT OPERATING COST	PROVIDER NO: 420002	PERIOD: FROM 06/01/2009 TO 05/31/2010	WORKSHEET D-1, PART I	
Medicare -Title XVIII - Subprovider 1 - 42S002					
PART I - ALL PROVIDER COMPONENTS					
	INPATIENT DAYS				
1	Inpatient days (including private room days, and swing-bed days, excluding new born)			3,936	1
2	Inpatient days (including private room days, excluding swing-bed days and new born days)			3,936	2
3	Private room days (excluding swing-bed private room days)			924	3
4	Semi-private room days (excluding swing-bed private room days)			3,012	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period				5
6	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)				6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period				7
8	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)				8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and new born days)			1,222	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period				10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after Decmeber 31 of the cost reporting period				11
12	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				12
13	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)				13
14	Medically necessary private room days applicable to the Program (excluding swing-bed days)			328	14
15	Total nursery days				15
16	Title V or XIX nursery days				16
	SWING BED ADJUSTEMENT				
17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period				17
18	Medicare rate for swing-bed SNF services applicable to services after Decmeber 31 of the cost reporting period				18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period				19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period				20
21	Total general inpatient routine service cost (see instructions)			3,318,521	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 × line 17)				22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 × line 18)				23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 × line 18)				24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 × line 20)				25
26	Total swing-bed cost (sum of lines 22 through 25)				26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			3,318,521	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28	General inpatient routine service charges (excluding swing-bed charges)			4,987,875	28
29	Private room charges (excluding swing-bed charges)			1,217,825	29
30	Semi-private room charges (excluding swing-bed charges)			3,770,050	30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.665318	31
32	Average private room per diem charge (line 29 ÷ line 3)			1,317.99	32
33	Average semi-private room per diem charge (line 30 ÷ line 4)			1,251.68	33
34	Average per diem private room charge differential (line 32 minus line 33)			66.31	34
35	Average per diem private private room cost differential (line 34 × line 31)			44.12	35
36	Private room cost differential adjustment (line 3 × line 35)			40,767	36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			3,277,754	37

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PIEDMONT MEDICAL CENTER - ROCK HILL, SC
Cost report status - As Submitted
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	COMPUTATION OF INPATIENT OPERATING COST	PROVIDER NO: 420002	PERIOD: FROM 06/01/2009 TO 05/31/2010	WORKSHEET D-1, PART I	
Medicaid - Title XIX - Hospital - 420002					
PART I - ALL PROVIDER COMPONENTS					
	INPATIENT DAYS				
1	Inpatient days (including private room days, and swing-bed days, excluding new born)			52,476	1
2	Inpatient days (including private room days, excluding swing-bed days and new born days)			52,476	2
3	Private room days (excluding swing-bed private room days)			31,810	3
4	Semi-private room days (excluding swing-bed private room days)			20,666	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period				5
6	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)				6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period				7
8	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)				8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and new born days)			8,115	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period				10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after Decmeber 31 of the cost reporting period				11
12	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				12
13	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)				13
14	Medically necessary private room days applicable to the Program (excluding swing-bed days)				14
15	Total nursery days			5,304	15
16	Title V or XIX nursery days			2,564	16
	SWING BED ADJUSTEMENT				
17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period				17
18	Medicare rate for swing-bed SNF services applicable to services after Decmeber 31 of the cost reporting period				18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period				19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period				20
21	Total general inpatient routine service cost (see instructions)			41,737,673	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 × line 17)				22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 × line 18)				23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 × line 18)				24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 × line 20)				25
26	Total swing-bed cost (sum of lines 22 through 25)				26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			41,737,673	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28	General inpatient routine service charges (excluding swing-bed charges)			54,560,245	28
29	Private room charges (excluding swing-bed charges)			24,435,990	29
30	Semi-private room charges (excluding swing-bed charges)			30,124,255	30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.764983	31
32	Average private room per diem charge (line 29 ÷ line 3)			768.19	32
33	Average semi-private room per diem charge (line 30 ÷ line 4)			1,457.67	33
34	Average per diem private room charge differential (line 32 minus line 33)				34
35	Average per diem private private room cost differential (line 34 × line 31)				35
36	Private room cost differential adjustment (line 3 × line 35)				36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			41,737,673	37

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PIEDMONT MEDICAL CENTER - ROCK HILL, SC
Cost report status - As Submitted
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	COMPUTATION OF INPATIENT OPERATING COST	PROVIDER NO: 420002	PERIOD: FROM 06/01/2009 TO 05/31/2010	WORKSHEET D-1, PART I	
Medicaid - Title XIX - Subprovider 1 - 42S002					
PART I - ALL PROVIDER COMPONENTS					
	INPATIENT DAYS				
1	Inpatient days (including private room days, and swing-bed days, excluding new born)			3,936	1
2	Inpatient days (including private room days, excluding swing-bed days and new born days)			3,936	2
3	Private room days (excluding swing-bed private room days)			924	3
4	Semi-private room days (excluding swing-bed private room days)			3,012	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period				5
6	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)				6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period				7
8	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)				8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and new born days)			856	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period				10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after Decmeber 31 of the cost reporting period				11
12	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				12
13	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)				13
14	Medically necessary private room days applicable to the Program (excluding swing-bed days)				14
15	Total nursery days				15
16	Title V or XIX nursery days				16
	SWING BED ADJUSTEMENT				
17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period				17
18	Medicare rate for swing-bed SNF services applicable to services after Decmeber 31 of the cost reporting period				18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period				19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period				20
21	Total general inpatient routine service cost (see instructions)			3,309,969	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 × line 17)				22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 × line 18)				23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 × line 18)				24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 × line 20)				25
26	Total swing-bed cost (sum of lines 22 through 25)				26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			3,309,969	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28	General inpatient routine service charges (excluding swing-bed charges)			4,987,875	28
29	Private room charges (excluding swing-bed charges)			1,217,825	29
30	Semi-private room charges (excluding swing-bed charges)			3,770,050	30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.663603	31
32	Average private room per diem charge (line 29 ÷ line 3)			1,317.99	32
33	Average semi-private room per diem charge (line 30 ÷ line 4)			1,251.68	33
34	Average per diem private room charge differential (line 32 minus line 33)			66.31	34
35	Average per diem private private room cost differential (line 34 × line 31)			44.00	35
36	Private room cost differential adjustment (line 3 × line 35)			40,656	36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			3,269,313	37

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PIEDMONT MEDICAL CENTER - ROCK HILL, SC
Cost report status - As Submitted
[Record code 274727 - 1996]

COMPUTATION OF INPATIENT OPERATING COST	PROVIDER NO: 420002	PERIOD: FROM 06/01/2009 TO 05/31/2010	WORKSHEET D-1, PART II

Medicare -Title XVIII - Hospital - 420002

	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				1	
38	Adjusted general inpatient routine service cost per diem (see instructions)				795.37	38
39	Program general inpatient routine service cost (line 9 × line 38)				20,410,785	39
40	Medically necessary private room cost applicable to the Program (line 14 × line 35)					40
41	Total Program general inpatient routine service cost (line 39 + line 40)				20,410,785	41
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 × col. 4)	
		1	2	3	4	5	
42	Nursery (title V & XIX only)	3,414,559					42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit	8,209,220	5,358	1532.14	3,125	4,787,938	43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47.00	Other Special Care (specify)						47.00
						1	
48	Program inpatient ancillary service cost (Wkst. D-4, col. 3, line 101)					29,570,943	48
49	Total Program inpatient costs (sum of lines 41 through 48) (see instructions)					54,769,666	49
	PASS THROUGH COST ADJUSTMENTS						
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					2,544,686	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					1,316,098	51
52	Total Program excludable cost (sum of lines 50 and 51)					3,860,784	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist, and medical education costs (line 49 minus line 52)					50,908,882	53
	TARGET AMOUNT AND LIMIT COMPUTATION						
54	Program discharges						54
55	Target amount per discharge						55
56	Target amount (line 54 × line 55)						56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57
58	Bonus payment (see instructions)						58
58.01	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						58.01
58.02	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						58.02
58.03	If lines 53/54 is less than the lower of lines 55, 58.01 or 58.02 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 × 58.02), or 1 percent of the target amount (line 56), otherwise enter zero						58.03
58.04	Relief payment (see instructions)						58.04
59	Allowable inpatient cost plus incentive payment (see instructions)						59
	PROGRAM INPATIENT ROUTINE SWING BED COST						
60	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (line 10 × line 17) (title XVIII only)						60
61	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (line 11 × line 18) (title XVIII only)						61
62	Total Medicare swing-bed SNF inpatient routine cost (line 60 plus line 61) (title XVIII)						62
63	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 × line 19)						63
64	Title V or XIX swing-bed NF inpatient routine csts after December 31 of the cost reporting period (line 13 × line 20)						64
65	Total title V or XIX swing-bed NF inpatient routine costs (line 63 + line 64)						65

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COMPUTATION OF INPATIENT OPERATING COST	PROVIDER NO: 420002	PERIOD: FROM 06/01/2009 TO 05/31/2010	WORKSHEET D-1, PART II

Medicare -Title XVIII - Subprovider 1 - 42S002

	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	1	
38	Adjusted general inpatient routine service cost per diem (see instructions)	843.12	38
39	Program general inpatient routine service cost (line 9 × line 38)	1,030,293	39
40	Medically necessary private room cost applicable to the Program (line 14 × line 35)		40
41	Total Program general inpatient routine service cost (line 39 + line 40)	1,030,293	41

		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 × col. 4)	
		1	2	3	4	5	
42	Nursery (title V & XIX only)	3,414,559					42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit	8,209,220	5,358	1532.14			43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47.00	Other Special Care (specify)						47.00

		1	
48	Program inpatient ancillary service cost (Wkst. D-4, col. 3, line 101)	182,342	48
49	Total Program inpatient costs (sum of lines 41 through 48) (see instructions)	1,212,635	49
	PASS THROUGH COST ADJUSTMENTS		
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	119,610	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	6,515	51
52	Total Program excludable cost (sum of lines 50 and 51)	126,125	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist, and medical education costs (line 49 minus line 52)	1,086,510	53
	TARGET AMOUNT AND LIMIT COMPUTATION		
54	Program discharges		54
55	Target amount per discharge		55
56	Target amount (line 54 × line 55)		56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57
58	Bonus payment (see instructions)		58
58.01	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket		58.01
58.02	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket		58.02
58.03	If lines 53/54 is less than the lower of lines 55, 58.01 or 58.02 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 × 58.02), or 1 percent of the target amount (line 56), otherwise enter zero		58.03
58.04	Relief payment (see instructions)		58.04
59	Allowable inpatient cost plus incentive payment (see instructions)		59
	PROGRAM INPATIENT ROUTINE SWING BED COST		
60	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (line 10 × line 17) (title XVIII only)		60
61	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (ilne 11 × line 18) (title XVIII only)		61
62	Total Medicare swing-bed SNF inpatient routine cost (line 60 plus line 61) (title XVIII)		62
63	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 × line 19)		63
64	Title V or XIX swing-bed NF inpatient routine csts after December 31 of the cost reporting period (line 13 × line 20)		64
65	Total title V or XIX swing-bed NF inpatient routine costs (line 63 + line 64)		65

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COMPUTATION OF INPATIENT OPERATING COST	PROVIDER NO: 420002	PERIOD: FROM 06/01/2009 TO 05/31/2010	WORKSHEET D-1, PART II

Medicaid - Title XIX - Hospital - 420002

	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	1	
38	Adjusted general inpatient routine service cost per diem (see instructions)	795.37	38
39	Program general inpatient routine service cost (line 9 × line 38)	6,454,428	39
40	Medically necessary private room cost applicable to the Program (line 14 × line 35)		40
41	Total Program general inpatient routine service cost (line 39 + line 40)	6,454,428	41

		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 × col. 4)	
		1	2	3	4	5	
42	Nursery (title V & XIX only)	3,414,559	5,304	643.77	2,564	1,650,626	42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit	8,209,220	5,358	1532.14	809	1,239,501	43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47.00	Other Special Care (specify)						47.00

		1	
48	Program inpatient ancillary service cost (Wkst. D-4, col. 3, line 101)	5,722,645	48
49	Total Program inpatient costs (sum of lines 41 through 48) (see instructions)	15,067,200	49
	PASS THROUGH COST ADJUSTMENTS		
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	1,041,150	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	338,355	51
52	Total Program excludable cost (sum of lines 50 and 51)	1,379,505	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist, and medical education costs (line 49 minus line 52)	13,687,695	53
	TARGET AMOUNT AND LIMIT COMPUTATION		
54	Program discharges		54
55	Target amount per discharge		55
56	Target amount (line 54 × line 55)		56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57
58	Bonus payment (see instructions)		58
58.01	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket		58.01
58.02	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket		58.02
58.03	If lines 53/54 is less than the lower of lines 55, 58.01 or 58.02 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 × 58.02), or 1 percent of the target amount (line 56), otherwise enter zero		58.03
58.04	Relief payment (see instructions)		58.04
59	Allowable inpatient cost plus incentive payment (see instructions)		59
	PROGRAM INPATIENT ROUTINE SWING BED COST		
60	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (line 10 × line 17) (title XVIII only)		60
61	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (line 11 × line 18) (title XVIII only)		61
62	Total Medicare swing-bed SNF inpatient routine cost (line 60 plus line 61) (title XVIII)		62
63	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 × line 19)		63
64	Title V or XIX swing-bed NF inpatient routine cst after December 31 of the cost reporting period (line 13 × line 20)		64
65	Total title V or XIX swing-bed NF inpatient routine costs (line 63 + line 64)		65

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COMPUTATION OF INPATIENT OPERATING COST	PROVIDER NO: 420002	PERIOD: FROM 06/01/2009 TO 05/31/2010	WORKSHEET D-1, PART II

Medicaid - Title XIX - Subprovider 1 - 42S002

	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS					1	
38	Adjusted general inpatient routine service cost per diem (see instructions)					830.62	38
39	Program general inpatient routine service cost (line 9 × line 38)					711,011	39
40	Medically necessary private room cost applicable to the Program (line 14 × line 35)						40
41	Total Program general inpatient routine service cost (line 39 + line 40)					711,011	41
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 × col. 4)	
		1	2	3	4	5	
42	Nursery (title V & XIX only)	3,414,559					42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit	8,209,220	5,358	1532.14			43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47.00	Other Special Care (specify)						47.00
						1	
48	Program inpatient ancillary service cost (Wkst. D-4, col. 3, line 101)						48
49	Total Program inpatient costs (sum of lines 41 through 48) (see instructions)					711,011	49
	PASS THROUGH COST ADJUSTMENTS						
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						51
52	Total Program excludable cost (sum of lines 50 and 51)						52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist, and medical education costs (line 49 minus line 52)						53
	TARGET AMOUNT AND LIMIT COMPUTATION						
54	Program discharges						54
55	Target amount per discharge						55
56	Target amount (line 54 × line 55)						56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57
58	Bonus payment (see instructions)						58
58.01	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						58.01
58.02	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						58.02
58.03	If lines 53/54 is less than the lower of lines 55, 58.01 or 58.02 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 × 58.02), or 1 percent of the target amount (line 56), otherwise enter zero						58.03
58.04	Relief payment (see instructions)						58.04
59	Allowable inpatient cost plus incentive payment (see instructions)						59
	PROGRAM INPATIENT ROUTINE SWING BED COST						
60	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (line 10 × line 17) (title XVIII only)						60
61	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (line 11 × line 18) (title XVIII only)						61
62	Total Medicare swing-bed SNF inpatient routine cost (line 60 plus line 61) (title XVIII)						62
63	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 × line 19)						63
64	Title V or XIX swing-bed NF inpatient routine csts after December 31 of the cost reporting period (line 13 × line 20)						64
65	Total title V or XIX swing-bed NF inpatient routine costs (line 63 + line 64)						65

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Medicare -Title XVIII - Hospital - 420002

PART III - SKILLED NURSING FACILITY, NURSING FACILITY AND ICF/MR ONLY

66	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)		66
67	Adjusted general inpatient routine service cost per diem (line 66 ÷ line 2)		67
68	Program routine service cost (line 9 × line 67)		68
69	medically necessary private room cost applicable to Program (line 14 × line 35)		69
70	Total Program general inpatient routine service costs (line 68 + line 69)		70
71	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, sum of Parts II and III, column 27)		71
72	Per diem capital-related costs (line 71 ÷ line 2)		72
73	Program capital-related costs (line 9 × line 72)		73
74	Inpatient routine service cost (line 70 minus line 73)		74
75	Aggregate charges to beneficiaries for excess costs (from provider records)		75
76	Total Program routine services costs for comparison to the cost limitation (line 74 minus line 75)		76
77	Inpatient routine service cost per diem limitation		77
78	Inpatient routine service cost limitation (line 9 × line 77)		78
79	Reasonable inpatient routine service costs (see instructions)		79
80	Program inpatient ancillary services (see instructions)		80
81	Utilization review - physician compensation		81
82	Total Program inpatient operating costs (sum of lines 79 through 81)		82

PART IV - PART IV - COMPUTATION OF OBSERVATION BED COST

83	Total observation bed days (see instructions)	1,957	83
84	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	795.37	84
85	Observation bed cost (line 83 × line 84) (see instructions)	1,556,539	85

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

		Cost	Routine Cost (from line 27)	col. 1 ÷ col. 2	Total Observation Bed Cost (from line 85)	Observation Bed Pass Through Cost (col. 3 × col. 4) (see instructions)	
		1	2	3	4	5	
86	Old capital-related cost	436,900	41,737,673	0.010468	1,556,539	16,294	86
87	New capital-related cost	3,905,282	41,737,673	0.093567	1,556,539	145,641	87
88	Non Physician Anesthetist		41,737,673		1,556,539		88
89	Medical Education		41,737,673		1,556,539		89

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Medicare -Title XVIII - Subprovider 1 - 42S002

PART III - SKILLED NURSING FACILITY, NURSING FACILITY AND ICF/MR ONLY

66	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)		66
67	Adjusted general inpatient routine service cost per diem (line 66 ÷ line 2)		67
68	Program routine service cost (line 9 × line 67)		68
69	medically necessary private room cost applicable to Program (line 14 × line 35)		69
70	Total Program general inpatient routine service costs (line 68 + line 69)		70
71	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, sum of Parts II and III, column 27)		71
72	Per diem capital-related costs (line 71 ÷ line 2)		72
73	Program capital-related costs (line 9 × line 72)		73
74	Inpatient routine service cost (line 70 minus line 73)		74
75	Aggregate charges to beneficiaries for excess costs (from provider records)		75
76	Total Program routine services costs for comparison to the cost limitation (line 74 minus line 75)		76
77	Inpatient routine service cost per diem limitation		77
78	Inpatient routine service cost limitation (line 9 × line 77)		78
79	Reasonable inpatient routine service costs (see instructions)		79
80	Program inpatient ancillary services (see instructions)		80
81	Utilization review - physician compensation		81
82	Total Program inpatient operating costs (sum of lines 79 through 81)		82

PART IV - PART IV - COMPUTATION OF OBSERVATION BED COST

83	Total observation bed days (see instructions)		83
84	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	843.12	84
85	Observation bed cost (line 83 × line 84) (see instructions)		85

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

		Cost	Routine Cost (from line 27)	col. 1 ÷ col. 2	Total Observation Bed Cost (from line 85)	Observation Bed Pass Through Cost (col. 3 × col. 4) (see instructions)	
		1	2	3	4	5	
86	Old capital-related cost		3,318,521				86
87	New capital-related cost		3,318,521				87
88	Non Physician Anesthetist		3,318,521				88
89	Medical Education		3,318,521				89

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COMPUTATION OF INPATIENT OPERATING COST	PROVIDER NO: 420002	PERIOD: FROM 06/01/2009 TO 05/31/2010	WORKSHEET D-1, PARTS III & IV

Medicaid - Title XIX - Hospital - 420002

	PART III - SKILLED NURSING FACILITY, NURSING FACILITY AND ICF/MR ONLY		
66	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)		66
67	Adjusted general inpatient routine service cost per diem (line 66 ÷ line 2)		67
68	Program routine service cost (line 9 × line 67)		68
69	medically necessary private room cost applicable to Program (line 14 × line 35)		69
70	Total Program general inpatient routine service costs (line 68 + line 69)		70
71	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, sum of Parts II and III, column 27)		71
72	Per diem capital-related costs (line 71 ÷ line 2)		72
73	Program capital-related costs (line 9 × line 72)		73
74	Inpatient routine service cost (line 70 minus line 73)		74
75	Aggregate charges to beneficiaries for excess costs (from provider records)		75
76	Total Program routine services costs for comparison to the cost limitation (line 74 minus line 75)		76
77	Inpatient routine service cost per diem limitation		77
78	Inpatient routine service cost limitation (line 9 × line 77)		78
79	Reasonable inpatient routine service costs (see instructions)		79
80	Program inpatient ancillary services (see instructions)		80
81	Utilization review - physician compensation		81
82	Total Program inpatient operating costs (sum of lines 79 through 81)		82
	PART IV - PART IV - COMPUTATION OF OBSERVATION BED COST		
83	Total observation bed days (see instructions)	1,957	83
84	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	795.37	84
85	Observation bed cost (line 83 × line 84) (see instructions)	1,556,539	85

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

		Cost	Routine Cost (from line 27)	col. 1 ÷ col. 2	Total Observation Bed Cost (from line 85)	Observation Bed Pass Through Cost (col. 3 × col. 4) (see instructions)	
		1	2	3	4	5	
86	Old capital-related cost	436,900	41,737,673	0.010468	1,556,539	16,294	86
87	New capital-related cost	3,905,282	41,737,673	0.093567	1,556,539	145,641	87
88	Non Physician Anesthetist		41,737,673		1,556,539		88
89	Medical Education		41,737,673		1,556,539		89

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COMPUTATION OF INPATIENT OPERATING COST	PROVIDER NO: 420002	PERIOD: FROM 06/01/2009 TO 05/31/2010	WORKSHEET D-1, PARTS III & IV

Medicaid - Title XIX - Subprovider 1 - 42S002

PART III - SKILLED NURSING FACILITY, NURSING FACILITY AND ICF/MR ONLY

66	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)		66
67	Adjusted general inpatient routine service cost per diem (line 66 ÷ line 2)		67
68	Program routine service cost (line 9 × line 67)		68
69	medically necessary private room cost applicable to Program (line 14 × line 35)		69
70	Total Program general inpatient routine service costs (line 68 + line 69)		70
71	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, sum of Parts II and III, column 27)		71
72	Per diem capital-related costs (line 71 ÷ line 2)		72
73	Program capital-related costs (line 9 × line 72)		73
74	Inpatient routine service cost (line 70 minus line 73)		74
75	Aggregate charges to beneficiaries for excess costs (from provider records)		75
76	Total Program routine services costs for comparison to the cost limitation (line 74 minus line 75)		76
77	Inpatient routine service cost per diem limitation		77
78	Inpatient routine service cost limitation (line 9 × line 77)		78
79	Reasonable inpatient routine service costs (see instructions)		79
80	Program inpatient ancillary services (see instructions)		80
81	Utilization review - physician compensation		81
82	Total Program inpatient operating costs (sum of lines 79 through 81)		82

PART IV - PART IV - COMPUTATION OF OBSERVATION BED COST

83	Total observation bed days (see instructions)		83
84	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	840.95	84
85	Observation bed cost (line 83 × line 84) (see instructions)		85

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

		Cost	Routine Cost (from line 27)	col. 1 ÷ col. 2	Total Observation Bed Cost (from line 85)	Observation Bed Pass Through Cost (col. 3 × col. 4) (see instructions)	
		1	2	3	4	5	
86	Old capital-related cost		3,309,969				86
87	New capital-related cost		3,309,969				87
88	Non Physician Anesthetist		3,309,969				88
89	Medical Education		3,309,969				89

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PIEDMONT MEDICAL CENTER - ROCK HILL, SC
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	PROVIDER NO: 420002	PERIOD: FROM 06/01/2009 TO 05/31/2010	WORKSHEET D-4

Medicare -Title XVIII - Hospital - 420002

	COST CENTER DESCRIPTION	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 × col. 2)	
		1	2	3	
(A)	INPATIENT ROUTINE SERVICE COST CENTERS				
25	Adults and Pediatrics (General Routine Care)		27,552,484		25
26	Intensive Care Units		6,949,771		26
27	Coronary Care Unit				27
28	Burn Intensive Care Unit				28
29	Surgical Intensive Care Unit				29
30.00	Other Special Care (specify)				30.00
31.00	Subprovider				31.00
	ANCILLARY SERVICE COST CENTERS				
37.05	Operating Room	0.313553	10,470,482	3,283,051	37.05
38	Recovery Room				38
39.05	Delivery Room & Labor Room	0.586945	13,388	7,858	39.05
40.00	Anesthesiology				40.00
41.05	Radiology-Diagnostic	0.153201	7,655,567	1,172,841	41.05
42.00	Radiology-Therapeutic				42.00
43	Radioisotope				43
44.05	Laboratory	0.214058	16,140,631	3,455,031	44.05
44.45	Vascular Lab	0.114633	8,004,489	917,579	44.45
45	PBP Clinic Laboratory Services-Program Only				45
46.00	Whole Blood & Packed Red Blood Cells				46.00
47	Blood Storing, Processing, & Transfusing				47
48	Intravenous Therapy	0.118690	10,352,354	1,228,721	48
49.05	Respiratory Therapy	0.286633	5,446,969	1,561,281	49.05
50.05	Physical Therapy	0.414054	1,305,559	540,572	50.05
51	Occupational Therapy	0.344496	158,113	54,469	51
52	Speech Pathology	0.352716	264,231	93,199	52
53.05	Electrocardiology	0.127577	3,880,680	495,086	53.05
54	Electroencephalography	0.356713	301,733	107,632	54
55	Medical Supplies Charged to Patients	0.255990	15,634,377	4,002,244	55
55.30	Implantable Devices Charged to Patients	0.549861	10,196,803	5,606,824	55.30
56	Drugs Charged to Patients	0.168294	32,430,137	5,457,797	56
57	Renal Dialysis	0.575112	832,029	478,510	57
58	ASC (Non-Distinct Part)				58
59.30	Other Ancillary Cost Centers	0.316610	1,425,604	122,690	59.30
	OUTPATIENT SERVICE COST CENTERS				
60.05	Clinic	0.456988	4,342	1,941	60.05
61	Emergency	0.341245	2,255,865	769,836	61
62.10	Observation Beds (Non-DistinctPart)	0.403751	529,486	213,781	62.10
63.00	Other Outpatient Service (specify)				63.00
	OTHER REIMBURSABLE COST CENTERS				
64	Home Program Dialysis				64
65	Ambulance				65
66.00	Durable Medical Equipment-Rented				66.00
67.00	Durable Medical Equipment-Sold				67.00
68	Other Reimbursable (specify)				68
101	Total (sum of lines 37-64 and 66-68)		127,302,839	29,570,943	101
102	Less PBP Clinic Laboratory Services-Program only charges (line 45)				102
103	Net Charges (line 101 minus line 102)		127,302,839		103

(A) Worksheet A line numbers

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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	PROVIDER NO: 420002	PERIOD: FROM 06/01/2009 TO 05/31/2010	WORKSHEET D-4

Medicare -Title XVIII - Subprovider 1 - 42S002

	COST CENTER DESCRIPTION	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 × col. 2)	
		1	2	3	
(A)	INPATIENT ROUTINE SERVICE COST CENTERS				
25	Adults and Pediatrics (General Routine Care)				25
26	Intensive Care Units				26
27	Coronary Care Unit				27
28	Burn Intensive Care Unit				28
29	Surgical Intensive Care Unit				29
30.00	Other Special Care (specify)				30.00
31.00	Subprovider		1,542,114		31.00
	ANCILLARY SERVICE COST CENTERS				
37.05	Operating Room	0.313553	26,207	8,217	37.05
38	Recovery Room				38
39.05	Delivery Room & Labor Room	0.586945			39.05
40.00	Anesthesiology				40.00
41.05	Radiology-Diagnostic	0.153201	35,615	5,456	41.05
42.00	Radiology-Therapeutic				42.00
43	Radioisotope				43
44.05	Laboratory	0.214058	124,969	26,751	44.05
44.45	Vascular Lab	0.114633			44.45
45	PBP Clinic Laboratory Services-Program Only				45
46.00	Whole Blood & Packed Red Blood Cells				46.00
47	Blood Storing, Processing, & Transfusing				47
48	Intravenous Therapy	0.118690	4,713	559	48
49.05	Respiratory Therapy	0.286633	8,700	2,494	49.05
50.05	Physical Therapy	0.414054	2,439	1,010	50.05
51	Occupational Therapy	0.344496	351	121	51
52	Speech Pathology	0.352716	253	89	52
53.05	Electrocardiology	0.127577	8,978	1,145	53.05
54	Electroencephalography	0.356713	845	301	54
55	Medical Supplies Charged to Patients	0.255990	9,345	2,392	55
55.30	Implantable Devices Charged to Patients	0.549861			55.30
56	Drugs Charged to Patients	0.168294	520,368	87,575	56
57	Renal Dialysis	0.575112	3,013	1,733	57
58	ASC (Non-Distinct Part)				58
59.30	Other Ancillary Cost Centers	0.316610	61,124	22,448	59.30
	OUTPATIENT SERVICE COST CENTERS				
60.05	Clinic	0.456988			60.05
61	Emergency	0.341245	64,616	22,051	61
62.10	Observation Beds (Non-DistinctPart)	0.403751			62.10
63.00	Other Outpatient Service (specify)				63.00
	OTHER REIMBURSABLE COST CENTERS				
64	Home Program Dialysis				64
65	Ambulance				65
66.00	Durable Medical Equipment-Rented				66.00
67.00	Durable Medical Equipment-Sold				67.00
68	Other Reimbursable (specify)				68
101	Total (sum of lines 37-64 and 66-68)		871,536	182,342	101
102	Less PBP Clinic Laboratory Services-Program only charges (line 45)				102
103	Net Charges (line 101 minus line 102)		871,536		103

(A) Worksheet A line numbers

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PIEDMONT MEDICAL CENTER - ROCK HILL, SC
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	PROVIDER NO: 420002	PERIOD: FROM 06/01/2009 TO 05/31/2010	WORKSHEET D-4

Medicaid - Title XIX - Hospital - 420002

	COST CENTER DESCRIPTION	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 × col. 2)	
		1	2	3	
(A)	**INPATIENT ROUTINE SERVICE COST CENTERS**				
25	Adults and Pediatrics (General Routine Care)		5,653,135		25
26	Intensive Care Units		917,660		26
27	Coronary Care Unit				27
28	Burn Intensive Care Unit				28
29	Surgical Intensive Care Unit				29
30.00	Other Special Care (specify)				30.00
31.00	Subprovider				31.00
	ANCILLARY SERVICE COST CENTERS				
37.05	Operating Room	0.313553	1,475,215	462,558	37.05
38	Recovery Room				38
39.05	Delivery Room & Labor Room	0.586945	2,100,994	1,233,168	39.05
40.00	Anesthesiology				40.00
41.05	Radiology-Diagnostic	0.153201	1,049,322	160,757	41.05
42.00	Radiology-Therapeutic				42.00
43	Radioisotope				43
44.05	Laboratory	0.214058	2,590,742	554,569	44.05
44.45	Vascular Lab	0.114633	586,605	67,244	44.45
45	PBP Clinic Laboratory Services-Program Only				45
46.00	Whole Blood & Packed Red Blood Cells				46.00
47	Blood Storing, Processing, & Transfusing				47
48	Intravenous Therapy	0.118690	2,501,023	296,846	48
49.05	Respiratory Therapy	0.286633	1,087,911	311,831	49.05
50.05	Physical Therapy	0.414054	126,628	52,431	50.05
51	Occupational Therapy	0.344496	25,975	8,948	51
52	Speech Pathology	0.352716	29,408	10,373	52
53.05	Electrocardiology	0.127577	376,563	48,041	53.05
54	Electroencephalography	0.356713	44,697	15,944	54
55	Medical Supplies Charged to Patients	0.255990	3,316,311	848,942	55
55.30	Implantable Devices Charged to Patients	0.549861	517,763	284,698	55.30
56	Drugs Charged to Patients	0.168294	6,735,292	1,133,509	56
57	Renal Dialysis	0.575112	61,465	35,349	57
58	ASC (Non-Distinct Part)				58
59.30	Other Ancillary Cost Centers	0.316610	239,520	39,482	59.30
	OUTPATIENT SERVICE COST CENTERS				
60.05	Clinic	0.456988			60.05
61	Emergency	0.341245	362,492	123,704	61
62.10	Observation Beds (Non-DistinctPart)	0.403751	84,832	34,251	62.10
63.00	Other Outpatient Service (specify)				63.00
	OTHER REIMBURSABLE COST CENTERS				
64	Home Program Dialysis				64
65	Ambulance				65
66.00	Durable Medical Equipment-Rented				66.00
67.00	Durable Medical Equipment-Sold				67.00
68	Other Reimbursable (specify)				68
101	Total (sum of lines 37-64 and 66-68)		23,312,758	5,722,645	101
102	Less PBP Clinic Laboratory Services-Program only charges (line 45)				102
103	Net Charges (line 101 minus line 102)		23,312,758		103

(A) Worksheet A line numbers

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	CALCULATION OF REIMBURSEMENT SETTLEMENT	PROVIDER NO: 420002	PERIOD: FROM: 06/01/2009 TO: 05/31/2010	WORKSHEET E, PART A	
Medicare -Title XVIII - Hospital - 420002					
	PART A - INPATIENT HOSPITAL SERVICES UNDER PPS		1	1.01	
	DRG Amount				
1	Other than Outlier Payments occurring prior to October 1		12,559,346		1
1.01	Other than Outlier Payments occurring on or after October 1 and before January 1		6,896,764		1.01
1.02	Other than Outlier Payments occurring on or after January 1		20,690,292		1.02
	Managed Care Patients				
1.03	Payments prior to March 1st or October 1st				1.03
1.04	Payments on or after October 1 and prior to January 1		25,090		1.04
1.05	Payments on or after January 1st but before April 1st/October 1st		31,363		1.05
1.06	Additional amount received or to be received (see instructions)				1.06
1.07	Payments for discharges on or after April 1, 2001 through September 30, 2001				1.07
1.08	Simulated payments from the PS&R on or afetr April 1, 2001 through September 30, 2001				1.08
2	Outlier payments for discharges occuring prior to October 1, 1997 (see instructions)				2
2.01	Outlier payments for discharges occurring on or after October 1, 1997 (see instructions)		1,378,885		2.01
	Indirect Medical Education Adjustment				
3	Bed days available divided by number of days in the cost reporting period (see instructions)		264.65		3
3.01	Number of Interns & Residents from Worksheet S-3, Part I				3.01
3.02	Indirect medical education percentage (see instructions)				3.02
3.03	Indirect medical education adjustment (sum of lines 1, 1.01, 1.02, and 2 times line 3.02)				3.03
3.04	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996				3.04
3.05	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with section 1886(d)(5)(B)(viii)				3.05
3.06	Adjusted FTE count for allopathic and osteopathic programs for affiliated programs in accordance with section 1886(d)(5)(B)(viii)				3.06
3.07	Sum of lines 3.04 through 3.06				3.07
3.08	FTE count for allopathic and osteopathic programs in the current year from your records				3.08
3.09	For cost reporting periods beginning before October 1, enter the percentage of discharges occurring prior to October 1				3.09
3.10	For cost reporting periods beginning before October 1, enter the percentage of discharges occurring on or after October 1				3.10
3.11	FTE count for the period identified in line 3.09				3.11
3.12	FTE count for the period identified in line 3.10				3.12
3.13	FTE count for residents in dental and podiatric programs				3.13
3.14	Current year allowable FTE (see instructions)				3.14
3.15	Total allowable FTE count for the prior year, if none but prior year teaching was in effect enter 1 here				3.15
3.16	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otehrwise enter zero. If there was no FTE count in this period but prior year teaching was in effect enter 1 here				3.16
3.17	Sum of lines 3.14 through 3.16 divided by the number of those lines in excess of zero (see instructions)				3.17
3.18	Current year residents to bed ratio (line 3.17 divided by line 3)				3.18
3.19	Prior year resident to bed ratio (see instructions)				3.19
3.20	For cost reporting periods beginning on or after October 1, 1997, enter the lesser of lines 3.18 or 3.19				3.20
3.21	IME payments for discharges occurring prior to October 1 (see instructions)				3.21
3.22	IME payments for discharges occurring on or after October 1 but before January 1 (see instructions)				3.22
3.23	IME payments for discharges occurring on or after January 1 (see instructions)				3.23
3.24	Sum of lines 3.21 through 3.23				3.24
	Disproportionate Share Adjustment				
4	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		0.080300		4
4.01	Percentage of Medicaid patient days to total days reported on Worksheet S-3, Part I		0.248000		4.01
4.02	Sum of lines 4 and 4.01		0.328300		4.02
4.03	Allowable disproportionate share percentage (see instructions)		0.163000		4.03
4.04	Disproportionate share adjustment (sum of lines 1, 1.01, 1.02, and 2 times line 4.03)		6,543,864		4.04
PART A - INPATIENT HOSPITAL SERVICES UNDER PPS					
	Additional payment for high percentage of ESRD beneficiary discharges				
5	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for DRGs 302, 316, 317 or MS-DRG 652, 682 - 685. (see instructions)				5
5.01	Total ESRD Medicare discharges excluding DRGs 302, 316, and 317, or MS-DRGs 652 and 682 - 685 (see instructions)				5.01
5.02	Divide line 5.01 by line 5 (if less than 10%, you do not qualify for adjustment)				5.02

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	CALCULATION OF REIMBURSEMENT SETTLEMENT	PROVIDER NO: 420002	PERIOD: FROM: 06/01/2009 TO: 05/31/2010	WORKSHEET E, PART A	
Medicare -Title XVIII - Hospital - 420002					
5.03	Total medicare ESRD inpatient days excluding DRGs 302, 316, 317, or MS-DRGs 652, 682 - 685.(see instructions)				5.03
5.04	Ratio of average length of stay to one week (line 5.03 divided by line 5.01 divided by 7)				5.04
5.05	Average weekly cost for dialysis treatments (see instructions)				5.05
5.06	Total additional payment (line 5.04 times line 5.05 times line 5.01)				5.06
6	Subtotal (see instructions)		48,069,151		6
7	Hospital specific payments (to be completed by SCH and MDC, small rural hospitals only)				7
7.01	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.See instructions FY beg. 10/1/00)				7.01
8	Total payment for inpatient operating costs (for SCH and MDH, small rural hospitals, higher of lines 6 or 7, all other providers, enter amount from line 6 on this line.)		48,069,151		8
9	Payment for inpatient program capital (from Worksheet L, parts I, II, or III, as applicable)		3,668,986		9
10	Exception payment for inpatient program capital (Worksheet L, Part IV, line 13)				10
11	Direct graduate medical eduation payment (from Worksheet E-3, Part IV)				11
11.01	Nursing and Allied Health Managed Care				11.01
11.02	Special add-on payments for new technologies				11.02
12	Net organ acquisition cost				12
13	Cost of teaching physicians				13
14	Routine service other pass through costs				14
15	Ancillary service other pass through costs				15
16	Total (sum of amounts on lines 8 through 15)		51,738,137		16
17	Primary payer payments		18,884		17
18	Total amount payable for program beneficiaries (line 16 minus line 17)		51,719,253		18
19	Deductibles billed to program beneficiaries		3,905,082		19
20	Coinsurance billed program beneficiaries		224,303		20
21	Reimbursable bad debts (see instructions)		1,174,913		21
21.01	Adjusted reimbursable bed debts (see instructions)		822,439		21.01
21.02	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		211,360		21.02
22	Subtotal (line 18 plus line 21.01 minus lines 19 and 20)		48,412,307		22
23	Recovery of excess depreciation resulting from provider termination or a decrease in program utilization				23
24	Other adjustments (see instructions) (specify)				24
24.99	Other adjustments - Outlier reconsiliation				24.99
25	Amounts applicable to prior cost reporting periods resulting from disposition of depreciable assets)				25
26	Amount due provider (line 22 plus or minus lines 24 and 25 minus line 23)		48,412,307		26
27	Sequestration adjustment (see instructions)				27
28	Interim payments		47,474,493		28
28.01	Tentative settlement (for fiscal intermediary use only)				28.01
29	Balance due provider (Program) (line 26 minus the sum of lines 27, 28, and 28.01)		937,814		29
30	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		1,212,848		30
TO BE COMPLETED BY INTERMEDIARY					
50	Operating outlier amount from Worksheet E, Part A line 2.01				50
51	Capital outlier amount from Worksheet L, Part I line 3.01				51
52	Operating outlier reconciliation adjustment amount (see instructions)				52
53	Capital outlier reconciliation adjustment amount (see instructions)				53
54	The rate used to calculate the Time Value of Money (see instructions)				54
55	Operating Time Value of Money (see instructions)				55
56	Capital Time Value of Money (see instructions)				56

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	CALCULATION OF REIMBURSEMENT SETTLEMENT	PROVIDER NO: 420002	PERIOD: FROM 06/01/2009 TO 05/31/2010	WORKSHEET E PART B	
Medicare -Title XVIII - Hospital - 420002					
PART B - MEDICAL AND OTHER HEALTH SERVICES					
1	Medical and other services (see instructions)			26,493	1
1.01	Medical and other services rendered on or after August 1, 2000 from Worksheet D, Part V, column 9.01, line 104			15,959,184	1.01
1.02	PPS payments received including outliers			16,771,894	1.02
1.03	Enter the 1996 hospital specific payment to cost ratio			0.911000	1.03
1.04	Line 1.01 times line 1.03			14,538,817	1.04
1.05	Line 1.02 divided by line 1.04			1.153594	1.05
1.06	Transitional corridor payment (see instructions)				1.06
1.07	Enter the amount from Worksheet D, Part IV, column 9, line 101				1.07
2	Interns and residents				2
3	Organ acquisitions				3
4	Cost of teaching physicians				4
5	Total cost (see instructions)			26,493	5
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable charges				
6	Ancillary service charges			156,592	6
7	Interns and residents service charges				7
8	Organ acquisition charges (from Worksheet D-6, Part III, line 61, col. 4)				8
9	Charges of professional services of teaching physicians				9
10	Total reasonable charges (sum of lines 6 through 9)			156,592	10
	Customary charges				
11	Aggregate amount actually collected from patients liable for payment for services on a charge basis				11
12	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)				12
13	Ratio of line 11 to line 12 (not to exceed 1.000000)				13
14	Total customary charges (see instructions)			156,592	14
15	Excess of customary chages over reasonable cost (complete only if line 14 exceeds line 5) (see instructions)			130,099	15
16	Excess of reasonable cost over customary charges (complete only if line 5 exceeds line 14) (see instructions)				16
17	Lesser of cost or charges (line 5 or line 14) (see instructions)			26,493	17
17.01	Total prospective payment (sum of lines 1.01, 1.06, 1.07)			16,771,894	17.01
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18	Deductibles and coinsurance (see instructions)			622	18
18.01	Coinsurance relating to amount on line 17.01			3,755,918	18.01
19	Subtotal (line 17 minus line 18)			13,041,847	19
20	Sum of amounts from Worksheet E, Parts C, D, and E (see instructions)				20
21	Direct graduate medical education payments (from Worksheet E-3, Part IV)				21
22	ESRD direct medical education costs (from Worksheet E-3, Part IV)				22
23	Subtotal (sum of lines 19 through 22)			13,041,847	23
24	Primary payer payments			7,834	24
25	Subtotal (line 23 minus line 24)			13,034,013	25
	Reimbursable bad debts (exclude bad debts for professional services)				
26	Composite rate ESRD (from Worksheet I-5, line 9)				26
27	Bad debts (see instructions)			1,055,729	27
27.01	Adjusted reimbursable bad debts (see instructions)			739,010	27.01
27.02	Reimbursable bad debts for dual eligible beneficiaries			289,572	27.02
28	Subtotal (sum of lines 25, 26, and 27 or 27.01) (line 27.01 hospital and subprovider only)			13,773,023	28
29	Recovery of excess depreciation resulting from provider termination or a decrease in program utilization				29
30	Other adjustments (specify) (see instructions)				30
31	Amounts applicable to prior cost reporting periods resulting from disposition of depreciable assets				31
32	Subtotal (line 28 plus or minus lines 30 and 31 minus line 29)			13,773,023	32
33	Sequestration adjustment (see instructions)				33
34	Interim payments			13,327,135	34
34.01	Tentative settlement (for fiscal intermediary use only)				34.01
35	Balance due provider/program (line 32 minus the sum of ilnes 33, 34, and 34.01)			445,888	35
36	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			12,222	36
TO BE COMPLETED BY CONTRACTOR					
50	Original outlier amount (see instructions)				50
51	Outlier reconciliation amount (see instructions)				51

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	CALCULATION OF REIMBURSEMENT SETTLEMENT	PROVIDER NO: 420002	PERIOD: FROM 06/01/2009 TO 05/31/2010	WORKSHEET E PART B	
Medicare -Title XVIII - Hospital - 420002					
52	The rate used to calculate the Time Value of Money				52
53	Time Value of Money (see instructions)				53
54	Total (sum of lines 51 and 53)				54

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	CALCULATION OF REIMBURSEMENT SETTLEMENT	PROVIDER NO: 420002	PERIOD: FROM 06/01/2009 TO 05/31/2010	WORKSHEET E PART B	
Medicare -Title XVIII - Subprovider 1 - 42S002					
PART B - MEDICAL AND OTHER HEALTH SERVICES					
1	Medical and other services (see instructions)			370	1
1.01	Medical and other services rendered on or after August 1, 2000 from Worksheet D, Part V, column 9.01, line 104			133	1.01
1.02	PPS payments received including outliers			658	1.02
1.03	Enter the 1996 hospital specific payment to cost ratio			0.911000	1.03
1.04	Line 1.01 times line 1.03			121	1.04
1.05	Line 1.02 divided by line 1.04			5.438017	1.05
1.06	Transitional corridor payment (see instructions)				1.06
1.07	Enter the amount from Worksheet D, Part IV, column 9, line 101				1.07
2	Interns and residents				2
3	Organ acquisitions				3
4	Cost of teaching physicians				4
5	Total cost (see instructions)			370	5
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable charges				
6	Ancillary service charges			2,197	6
7	Interns and residents service charges				7
8	Organ acquisition charges (from Worksheet D-6, Part III, line 61, col. 4)				8
9	Charges of professional services of teaching physicians				9
10	Total reasonable charges (sum of lines 6 through 9)			2,197	10
	Customary charges				
11	Aggregate amount actually collected from patients liable for payment for services on a charge basis				11
12	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)				12
13	Ratio of line 11 to line 12 (not to exceed 1.000000)				13
14	Total customary charges (see instructions)			2,197	14
15	Excess of customary chages over reasonable cost (complete only if line 14 exceeds line 5) (see instructions)			1,827	15
16	Excess of reasonable cost over customary charges (complete only if line 5 exceeds line 14) (see instructions)				16
17	Lesser of cost or charges (line 5 or line 14) (see instructions)			370	17
17.01	Total prospective payment (sum of lines 1.01, 1.06, 1.07)			658	17.01
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18	Deductibles and coinsurance (see instructions)				18
18.01	Coinsurance relating to amount on line 17.01				18.01
19	Subtotal (line 17 minus line 18)			1,028	19
20	Sum of amounts from Worksheet E, Parts C, D, and E (see instructions)				20
21	Direct graduate medical education payments (from Worksheet E-3, Part IV)				21
22	ESRD direct medical education costs (from Worksheet E-3, Part IV)				22
23	Subtotal (sum of lines 19 through 22)			1,028	23
24	Primary payer payments				24
25	Subtotal (line 23 minus line 24)			1,028	25
	Reimbursable bad debts (exclude bad debts for professional services)				
26	Composite rate ESRD (from Worksheet I-5, line 9)				26
27	Bad debts (see instructions)				27
27.01	Adjusted reimbursable bad debts (see instructions)				27.01
27.02	Reimbursable bad debts for dual eligible beneficiaries				27.02
28	Subtotal (sum of lines 25, 26, and 27 or 27.01) (line 27.01 hospital and subprovider only)			1,028	28
29	Recovery of excess depreciation resulting from provider termination or a decrease in program utilization				29
30	Other adjustments (specify) (see instructions)				30
31	Amounts applicable to prior cost reporting periods resulting from disposition of depreciable assets				31
32	Subtotal (line 28 plus or minus lines 30 and 31 minus line 29)			1,028	32
33	Sequestration adjustment (see instructions)				33
34	Interim payments			1,097	34
34.01	Tentative settlement (for fiscal intermediary use only)				34.01
35	Balance due provider/program (line 32 minus the sum of ilnes 33, 34, and 34.01)			-69	35
36	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2				36
TO BE COMPLETED BY CONTRACTOR					
50	Original outlier amount (see instructions)				50
51	Outlier reconciliation amount (see instructions)				51

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Medicare -Title XVIII - Subprovider 1 - 42S002					
52	The rate used to calculate the Time Value of Money				52
53	Time Value of Money (see instructions)				53
54	Total (sum of lines 51 and 53)				54

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	CALCULATION OF REIMBURSEMENT SETTLEMENT	PROVIDER NO: 420002	PERIOD: FROM: 06/01/ 2009 TO: 05/31/2010	WORKSHEET E-3 PART 1	
Medicare -Title XVIII - Subprovider 1 - 42S002					
PART I - MEDICARE PART A SERVICES - TEFRA AND IRF PPS, LTCH PPS AND IPF PPS					
1	Inpatient hospital services (see instructions)				1
1.01	Hospital specific amount (see instructions)				1.01
1.02	Net Federal PPS Payments (see instructions)				1.02
1.03	Medicare SSI ratio (IRF PPS only) (see instructions)				1.03
1.04	Inpatient Rehabilitation LIP payment (see instructions)				1.04
1.05	Outlier Payments				1.05
1.06	Total PPS Payments {sum of lines 1.01, (1.02, 1.04, 1.42 for columns 1 and 1.01), and 1.05}				1.06
1.07	Nursing Allied Health Managed Care Payments				1.07
Inpatient Psychiatric Facility (IPF)					
1.08	Net Federal IPF PPS Payments (excluding outlier, ECT, scenterloss, and medical education payments)			856,263	1.08
1.09	Net IPF PPS Outlier Payments			264,025	1.09
1.10	Net IPF PPS ECT Payments				1.10
1.11	Unweighted intern and resident FTE count for latest cost report filed prior to November 15, 2004. (see instructions)				1.11
1.12	New Teaching program adjustment. (see instructions)				1.12
1.13	Current years unweighted FTE count of I&R other than FTEs in the first 3 years of a new teaching program. (see inst.)				1.13
1.14	Current years unweighted I&R FTE count for residents within the first 3 years of a new teaching program. (see inst.)				1.14
1.15	Intern and resident count for IPF PPS medical education adjustment (see instructions)				1.15
1.16	Average Daily Census (see instructions)			10.78	1.16
1.17	Medical Education Adjustment Factor {((1 + (line 1.15/line 1.16)) raised to the power of .5150 -1}.				1.17
1.18	Medical Education Adjustment (line 1.08 multiplied by line 1.17).				1.18
1.19	Adjusted Net IPF PPS Payments (sum of lines 1.08, 1.09, 1.10 and 1.18)			1,120,288	1.19
1.20	Scenter Loss Payment Floor (line 1 x 70%).				1.20
1.21	Adjusted Net Payment Floor (line 1.20 x the appropriate Federal blend percentage)				1.21
1.22	Scenter Loss Adjustment (If line 1.21 is greater than line 1.19 enter the amount on line 1.21 less line 1.19 otherwise enter -0-)				1.22
1.23	Total IPF PPS Payments (sum of lines 1.01, 1.19 and 1.22)			1,120,288	1.23
Inpatient Rehabilitation Facility (IRF)					
1.35	Unweighted intern and resident FTE count for cost report periods ending on/or prior to November 15, 2004. (see inst.)				1.35
1.36	New Teaching program adjustment. (see instructions)				1.36
1.37	Current years unweighted FTE count of I&R other than FTEs in the first 3 years of a new teaching program. (see inst.)				1.37
1.38	Current years unweighted I&R FTE count for residents within the first 3 years of a new teaching program. (see inst.)				1.38
1.39	Intern and resident count for IRF PPS medical education adjustment (see instructions)				1.39
1.40	Average Daily Census (see instructions)				1.40
1.41	Medical Education Adjustment Factor (see instructions).				1.41
1.42	Medical Education Adjustment (line 1.02 multiplied by line 1.41).				1.42
2	Organ acquisition				2
3	Cost of teaching physicians (from Worksheet D-9, Part II, column 3, line 16) (see instructions)				3
4	Subtotal (sum of lines 1.06, 2, and 3)			1,120,288	4
5	Primary payer payments			4,637	5
6	Subtotal (line 4 less line 5)			1,115,651	6
7	Deductibles			111,348	7
8	Subtotal (line 6 minus line 7)			1,004,303	8
9	Coinsurance			22,174	9
10	Subtotal (line 8 minus line 9)			982,129	10
11	Reimbursable bad debts (exclude bad debts for professional services) (see instructions)			39,935	11
11.01	Adjusted reimbursable bad debts (see instructions)			27,955	11.01
11.02	Reimbursable bad debts for dual eligible beneficiaries				11.02
12	Subtotal (sum of lines 10 and 11.01)			1,010,084	12
13	Direct graduate medical education payment (from Worksheet E-3, Part IV, line 24)				13
13.01	Other pass through costs (see instructions)				13.01
14	Recovery of excess depreciation resulting from provider termination or a decrease in program				14

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	CALCULATION OF REIMBURSEMENT SETTLEMENT	PROVIDER NO: 420002	PERIOD: FROM: 06/01/ 2009 TO: 05/31/2010	WORKSHEET E-3 PART 1	
Medicare -Title XVIII - Subprovider I - 42S002					
PART I - MEDICARE PART A SERVICES - TEFRA AND IRF PPS, LTCH PPS AND IPF PPS					
15	Other adjustments (see instructions) (specify)				15
16	Amounts applicable to prior cost reporting periods resulting from disposition of depreciable a				16
17	Total amount payable to the provider (see instructions)			1,010,084	17
18	Sequestration adjustment (see instructions)				18
19	Interim payments			1,005,322	19
19.01	Tentative settlement (for fiscal intermediary use only)				19.01
20	Balance due provider/program (line 17 minus the sum of lines 18, 19, and 19.01)			4,762	20
21	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section				21
TO BE COMPLETED BY INTERMEDIARY					
50	Operating outlier amount from Worksheet E-3, Part I line 1.05 or line 1.09				50
51	Operating Outlier reconciliation amount (see instructions)				51
52	The interest rate used to calculate the Time Value of Money				52
53	Operating Time Value of Money (see instructions)				53

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	CALCULATION OF REIMBURSEMENT SETTLEMENT	PROVIDER NO: 420002	PERIOD: FROM: 06/01/2009 TO: 05/31/2010	WORKSHEET E-3 PART III	
Medicaid - Title XIX - Hospital - 420002					
	COMPUTATION OF NET COST OF COVERED SERVICES		Title V or Title XIX	Title XVIII SNF PPS	
			1	2	
1	Inpatient hospital/SNF/NF services				1
2	Medical and other services		3,812,123		2
3	Interns and residents (see instructions)				3
4	Organ acquisition (certified transplant centers only)				4
5	Cost of teaching physicians (see instructions)				5
6	Subtotal (sum of lines 1 through 5)		3,812,123		6
7	Inpatient primary payer payments				7
8	Outpatient primary payer payments				8
9	Subtotal (line 6 less sum of lines 7 and 8)		3,812,123		9
COMPUTATION OF LESSER OF COST OR CHARGES					
	REASONABLE CHARGES				
10	Routine service charges		6,570,795		10
11	Ancillary service charges		36,356,287		11
12	Interns and residents service charges				12
13	Organ acquisition charges, net of revenue				13
14	Teaching physicians				14
15	Incentive from target amount computation				15
16	Total reasonable charges (sum of lines 10 through 15)		42,927,082		16
	CUSTOMARY CHARGES				
17	Amount actually collected from patients liable for payment for services on a charge basis				17
18	Amounts that would have been realized from patients liable for payment for a on charge basis had such payment been made in accordance with 42 CFR 4				18
19	Ratio of line 17 to line 18 (not to exceed 1.000000)				19
20	Total customary charges (see instructions)		42,927,082		20
21	Excess of customary charges over reasonable cost (complete only if line 20 exceeds line 9) (see instructions)		39,114,959		21
22	Excess of reasonable cost over customary charges (complete only if line 9 exceeds line 20) (see instructions)				22
23	Cost of covered services (line 9)		3,812,123		23
24	Other than outlier payments				24
25	Outlier payments				25
26	Program capital payments				26
27	Capital exception payments				27
28	Routine service other pass through costs				28
29	Ancillary service other pass through costs				29
30	Subtotal (sum of lines 23 through 29)		3,812,123		30
31	Customary charges (title XIX PPS covered services only)		42,888,967		31
32	Titles V or XIX PPS, lesser of lines 30 or 31; non PPS and title XVIII enter a		3,812,123		32
33	Deductibles (exclude professional component)				33
34	Excess of reasonable cost (from line 22)				34
35	Subtotal (line 32 minus sum of lines 33 and 34)		3,812,123		35
36	Coinsurance				36
37	Sum of the amounts from Wkst. E, Parts C, D, and E, line 19				37
38	Reimbursable bad debts (see instructions)				38
38.01	Adjusted reimbursable bad debts (see instructions)				38.01
38.02	Reimbursable bad debts for dual eligible beneficiaries				38.02
38.03	Adjusted reimbursable bad debts for periods ending on or after 10/01/05 (see instructions)				38.03
39	Utilization review				39
40	Subtotal (see instructions)		3,812,123		40
41	Inpatient routine service cost (Wkst. D-1, Part III, line 70)				41
42	Medicare inpatient routine charges (from your records)				42
43	Amount actually collected from patients liable for payment for services on a charge basis (see instructions)				43
44	Amounts that would have been realized from patients liable for payment of Part A services (see instructions)				44
45	Ratio of line 43 to line 44 (not to exceed 1.000000)				45
46	Total customary charges (see instructions)				46

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	CALCULATION OF REIMBURSEMENT SETTLEMENT	PROVIDER NO: 420002	PERIOD: FROM: 06/01/2009 TO: 05/31/2010	WORKSHEET E-3 PART III	
Medicaid - Title XIX - Hospital - 420002					
	COMPUTATION OF NET COST OF COVERED SERVICES		Title V or Title XIX	Title XVIII SNF PPS	
			1	2	
47	Excess of customary charges over reasonable cost (see instructions)				47
48	Excess of reasonable cost over customary charges (see instructions)				48
49	Recovery of excess depreciation resulting from provider termination or a decrease in program utilization				49
50	Other adjustments (see instructions) (specify)				50
51	Amounts applicable to prior cost reporting periods resulting from disposition of depreciable assets				51
52	Subtotal (line 40 ± lines 50 and 51, minus line 49)		3,812,123		52
53	Indirect medical education adjustment (PPS only) (see instructions)				53
54	Direct graduate medical education payments (from Wkst. E-3, Part IV)				54
55	Total amount payable to the provider (sum of lines 52, 53, and 54)		3,812,123		55
56	Sequestration adjustment (see instructions)				56
57	Interim payments		6,893,149		57
57.01	Tentative settlement (for fiscal intermediary use only)				57.01
58	Balance due provider/program (line 55 minus the sum of lines 56, 57, and 57.01)		-3,081,026		58
59	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2				59

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	CALCULATION OF REIMBURSEMENT SETTLEMENT	PROVIDER NO: 420002	PERIOD: FROM: 06/01/2009 TO: 05/31/2010	WORKSHEET E-3 PART III	
Medicaid - Title XIX - Subprovider 1 - 42S002					
	COMPUTATION OF NET COST OF COVERED SERVICES		Title V or Title XIX	Title XVIII SNF PPS	
			1	2	
1	Inpatient hospital/SNF/NF services		711,011		1
2	Medical and other services				2
3	Interns and residents (see instructions)				3
4	Organ acquisition (certified transplant centers only)				4
5	Cost of teaching physicians (see instructions)				5
6	Subtotal (sum of lines 1 through 5)		711,011		6
7	Inpatient primary payer payments				7
8	Outpatient primary payer payments				8
9	Subtotal (line 6 less sum of lines 7 and 8)		711,011		9
COMPUTATION OF LESSER OF COST OR CHARGES					
	REASONABLE CHARGES				
10	Routine service charges				10
11	Ancillary service charges				11
12	Interns and residents service charges				12
13	Organ acquisition charges, net of revenue				13
14	Teaching physicians				14
15	Incentive from target amount computation				15
16	Total reasonable charges (sum of lines 10 through 15)				16
	CUSTOMARY CHARGES				
17	Amount actually collected from patients liable for payment for services on a charge basis				17
18	Amounts that would have been realized from patients liable for payment for a on charge basis had such payment been made in accordance with 42 CFR 4				18
19	Ratio of line 17 to line 18 (not to exceed 1.000000)				19
20	Total customary charges (see instructions)				20
21	Excess of customary charges over reasonable cost (complete only if line 20 exceeds line 9) (see instructions)				21
22	Excess of reasonable cost over customary charges (complete only if line 9 exceeds line 20) (see instructions)		711,011		22
23	Cost of covered services (line 9)		711,011		23
24	Other than outlier payments				24
25	Outlier payments				25
26	Program capital payments				26
27	Capital exception payments				27
28	Routine service other pass through costs				28
29	Ancillary service other pass through costs				29
30	Subtotal (sum of lines 23 through 29)		711,011		30
31	Customary charges (title XIX PPS covered services only)				31
32	Titles V or XIX PPS, lesser of lines 30 or 31; non PPS and title XVIII enter a		711,011		32
33	Deductibles (exclude professional component)				33
34	Excess of reasonable cost (from line 22)		711,011		34
35	Subtotal (line 32 minus sum of lines 33 and 34)				35
36	Coinsurance				36
37	Sum of the amounts from Wkst. E, Parts C, D, and E, line 19				37
38	Reimbursable bad debts (see instructions)				38
38.01	Adjusted reimbursable bad debts (see instructions)				38.01
38.02	Reimbursable bad debts for dual eligible beneficiaries				38.02
38.03	Adjusted reimbursable bad debts for periods ending on or after 10/01/05 (see instructions)				38.03
39	Utilization review				39
40	Subtotal (see instructions)				40
41	Inpatient routine service cost (Wkst. D-1, Part III, line 70)				41
42	Medicare inpatient routine charges (from your records)				42
43	Amount actually collected from patients liable for payment for services on a charge basis (see instructions)				43
44	Amounts that would have been realized from patients liable for payment of Part A services (see instructions)				44
45	Ratio of line 43 to line 44 (not to exceed 1.000000)				45
46	Total customary charges (see instructions)				46

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Medicaid - Title XIX - Subprovider 1 - 42S002					
	COMPUTATION OF NET COST OF COVERED SERVICES		Title V or Title XIX	Title XVIII SNF PPS	
			1	2	
47	Excess of customary charges over reasonable cost (see instructions)				47
48	Excess of reasonable cost over customary charges (see instructions)				48
49	Recovery of excess depreciation resulting from provider termination or a decrease in program utilization				49
50	Other adjustments (see instructions) (specify)				50
51	Amounts applicable to prior cost reporting periods resulting from disposition of depreciable assets				51
52	Subtotal (line 40 ± lines 50 and 51, minus line 49)				52
53	Indirect medical education adjustment (PPS only) (see instructions)				53
54	Direct graduate medical education payments (from Wkst. E-3, Part IV)				54
55	Total amount payable to the provider (sum of lines 52, 53, and 54)				55
56	Sequestration adjustment (see instructions)				56
57	Interim payments				57
57.01	Tentative settlement (for fiscal intermediary use only)				57.01
58	Balance due provider/program (line 55 minus the sum of lines 56, 57, and 57.01)				58
59	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2				59

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BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)		PROVIDER NO: 420002	PERIOD: FROM 06/01/2009 TO 05/31/2010	WORKSHEET G		
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1	2	3	4	
	CURRENT ASSETS					
1	Cash on hand and in banks	12,318				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	62,300,126				4
5	Other receivables	4,481,545				5
6	Allowances for uncollectible notes and accounts receivable	28,301,521				6
7	Inventory	4,208,209				7
8	Prepaid expenses	1,319,831				8
9	Other current assets					9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	44,020,508				11
	FIXED ASSETS					
12	Land	2,050,000				12
13	Land improvements	1,189,399				13
13.01	Accumulated depreciation	214,719				13.01
14	Buildings	125,951,450				14
14.01	Accumulated depreciation	36,204,389				14.01
15	Leasehold improvements	696,016				15
15.01	Accumulated depreciation	224,625				15.01
16	Fixed equipment	3,470,606				16
16.01	Accumulated depreciation	1,822,872				16.01
17	Automobiles and trucks	1,405,787				17
17.01	Accumulated depreciation	935,019				17.01
18	Major movable equipment	64,870,145				18
18.01	Accumulated depreciation	38,095,122				18.01
19	Minor equipment depreciable					19
19.01	Accumulated depreciable					19.01
20	Minor equipment-nondepreciable	998,550				20
21	Total fixed assets (sum of lines 12-20)	123,135,207				21
	OTHER ASSETS					
22	Investments					22
23	Deposits on leases					23
24	Due from owners/officers					24
25	Other assets	93,477,419				25
26	Total other assets (sum of lines 22-25)	93,477,419				26
27	Total assets (sum of lines 11, 21, and 26)	260,633,134				27
	CURRENT LIABILITIES					
28	Accounts payable	8,111,286				28
29	Salaries, wages, and fees payable	5,663,033				29
30	Payroll taxes payable					30
31	Notes and loans payable (short term)	-99,559				31
32	Deferred income					32
33	Accelerated payments					33
34	Due to other funds					34
35	Other current liabilities	6,789,606				35
36	Total current liabilities (sum of lines 28 thru 35)	20,464,366				36
	LONG TERM LIABILITIES					

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BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)			PROVIDER NO 420002	PERIOD: FROM 06/01/2009 TO 05/31/2010	WORKSHEET G	
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1	2	3	4	
37	Mortgage payable					37
38	Notes payable	109,883,785				38
39	Unsecured loans					39
40	Loans from owners 40.01 Prior to 7/1/66 40.02 On or after 7/1/66					40.01
						40.02
41	Other long term liabilities					41
42	Total long term liabilities (sum of lines 37 thru 41)	109,883,785				42
43	Total liabilities (sum of lines 36 and 42)	130,348,151				43
	CAPITAL ACCOUNTS					
44	General fund balance	130,284,983				44
45	Specific purpose fund					45
46	Donor created - endowment fund balance - restricted					46
47	Donor created - endowment fund balance - unrestricted					47
48	Governing body created - endowment fund balance					48
49	Plant fund balance - invested in plant					49
50	Plant fund balance - reserve for plant improvement, replacement, and expansion					50
51	Total fund balances (sum of lines 44 thru 50)	130,284,983				51
52	Total liabilities and fund balances (sum of lines 43 and 51)	260,633,134				52

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PIEDMONT MEDICAL CENTER - ROCK HILL, SC
Cost report status - As Submitted
[Record code 274727 - 1996]

STATEMENT OF PATIENT REVENUES AND OPERATING REVENUES	PROVIDER NO: 420002	PERIOD: FROM 06/01/2009 TO 05/31/2010	WORKSHEET G-2 PARTS I & II	
PART I - PATIENT REVENUES				
REVENUE CENTER	INPATIENT	OUTPATIENT	TOTAL	
	1	2	3	
GENERAL INPATIENT ROUTINE CARE SERVICES				
1 Hospital	55,591,085		55,591,085	1
2.00 SubComponent 1 - 42S002	4,987,875		4,987,875	2.00
4 Swing bed - SNF				4
5 Swing bed - NF				5
6 Skilled nursing facility				6
7 Nursing facility				7
8 Other long term care				8
9 Total general inpatient care services (sum of lines 1-8)	60,578,960		60,578,960	9
INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
10 Intensive care unit	12,754,020		12,754,020	10
11 Coronary care unit				11
12 Burn intensive care unit				12
13 Surgical intensive care unit				13
14.00 Other Special Care (specify)				14.00
15 Total intensive care type inpatient hospital services (sum of lines 10-14)	12,754,020		12,754,020	15
16 Total inpatient routine care services (sum of lines 9 and 15)	73,332,980		73,332,980	16
17 Ancillary services	279,324,330	220,592,701	499,917,031	17
18 Outpatient services				18
19 Home health agency				19
20 Ambulance		8,657,585	8,657,585	20
21 Outpatient rehabilitation providers				21
22 ASC				22
23 Hospice				23
24	3,638,160		3,638,160	24
25 Total patient revenues (sum of lines 16-24) (transfer column 3 to Wkst. G-3, line 1)	356,295,470	229,250,286	585,545,756	25
PART II - OPERATING EXPENSES				
		1	2	
26 Operating expenses (per Wkst A, column 3, line 101)			216,729,550	26
27 Add (specify)				27
28				28
29				29
30				30
31				31
32				32
33 Total additions (sum of lines 27-32)			72,609	33
34 Deduct (specify)				34
35				35
36				36
37				37
38				38
39 Total deductions (sum of lines 34-38)				39
40 Total operating expenses (sum of lines 26 and 33 minus line 39) (transfer to Wkst. G-3, line 4)			216,802,159	40

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PIEDMONT MEDICAL CENTER - ROCK HILL, SC
Cost report status - As Submitted
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STATEMENT OF REVENUES AND EXPENSES	PROVIDER NO: 420002	PERIOD: FROM 06/01/2009 TO 05/31/2010	WORKSHEET G-3	
	Description			
1	Total patient revenues (from Wkst. G-2, Part I, column 3, line 25)		585,545,756	1
2	Less contractual allowances and discounts on patients' accounts		342,545,785	2
3	Net patient revenues (line 1 minus line 2)		242,999,971	3
4	Less total operating expenses (from Wkst. G-2, Part II, line 40)		216,802,159	4
5	Net income from service to patients (line 3 minus line 4)		26,197,812	5
OTHER INCOME				
6	Contributions, donations, bequests, etc.			6
7	Income from investments		12,608	7
8	Revenues from telephone and telegraph service			8
9	Revenue from television and radio service			9
10	Purchase discounts		96,710	10
11	Rebates and refunds of expenses		63,631	11
12	Parking lot receipts			12
13	Revenue from laundry and linen service			13
14	Revenue from meals sold to employees and guests			14
15	Revenue from rental of living quarters			15
16	Revenue from sale of medical and surgical supplies to other than patients			16
17	Revenue from sale of drugs to other than patients			17
18	Revenue from sale of medical records and abstracts		1,311	18
19	Tuition (fees, sales of textbooks, uniforms, etc.)		121,415	19
20	Revenue from gifts, flowers, coffee shops, and canteen			20
21	Rental of vending machines		22,550	21
22	Rental of hospital space			22
23	Governmental appropriations			23
24	Other (specify)		1,801,803	24
25	Total other income (sum of lines 6-24)		2,120,028	25
26	Total (line 5 plus line 25)		28,317,840	26
27	Other expenses (specify)			27
28				28
29				29
30	Total other expenses (sum of lines 27-29)			30
31	Net income (or loss) for the period (line 26 minus line 30)		28,317,840	31

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RECORD 007604

PIEDMONT MEDICAL CENTER - ROCK HILL, SC
Cost report status - As Submitted
[Record code 274727 - 1996]

Medicare -Title XVIII - Hospital - 420002				
CALCULATION OF CAPITAL PAYMENT	PROVIDER NO: 420002	PERIOD: FROM: 06/01/2009 TO: 05/31/2010	WORKSHEET L	
PART I - FULLY PROSPECTIVE METHOD				
1	Capital hospital specific rate payments			1
	Capital Federal Amount			
2	Capital DRG other than outlier		3,291,592	2
3	Capital DRG outlier payments for services rendered prior to October 1, 1997			3
3.01	Capital DRG outlier payments for services rendered on or after October 1, 1997		151,262	3.01
	Indirect Medical Education Adjustment			
4	Total inpatient days divided by number of days in the cost reporting period (see instructions)		153.09	4
4.01	Number of interns & residents (from Worksheet S-3, Part I, column 9, line 12)			4.01
4.02	Indirect medical education percentage (see instructions)			4.02
4.03	Indirect medical education adjustment (sum of lines 2 & 3 times line 4.02)			4.03
	Disproportionate Share Adjustment			
5	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		0	5
5.01	Percentage of Medicaid patient days to total days reported on Worksheet S-3, Part I (see instructions)		0.248000	5.01
5.02	Sum of lines 5 and 5.01		0.33	5.02
5.03	Allowable disproportionate share percentage (see instructions)		0.068700	5.03
5.04	Disproportionate share adjustment (sum of lines 2 & 3 times line 5.03)		226,132	5.04
6	Total prospective capital payments (sum of lines 1-3.01, 4.03, and 5.04)		3,668,986	6
PART II - HOLD HARMLESS METHOD				
1	New capital (see instructions)			1
2	Old capital (see instructions)			2
3	Total capital (sum of line 1 plus line 2)			3
4	Ratio of new capital to total capital (line 1 divided by line 3)			4
5	Total capital payments under 100% federal rate (see instructions)			5
6	Reduction factor for hold harmless payment (see instructions)			6
7	Reduced old capital amount (line 2 x line 6)			7
8	Hold harmless payment for new capital (line 5 x line 4)			8
9	Subtotal (line 7 plus line 8)			9
10	Payment under hold harmless (greater of line 5 or line 9)			10
PART III - PAYMENT UNDER REASONABLE COST				
1	Program inpatient routine capital cost (see instructions)			1
2	Program inpatient ancillary capital cost (see instructions)			2
3	Total inpatient program capital cost (line 1 plus line 2)			3
4	Capital cost payment factor (see instructions)			4
5	Total inpatient program capital cost (line 3 x line 4)			5
PART IV - COMPUTATION OF EXCEPTION PAYMENTS				
1	Program inpatient capital costs (see instructions)			1
2	Program inpatient capital costs for extraordinary circumstances (see instructions)			2
3	Net program inpatient capital costs (line 1 minus line 2)			3
4	Applicable exception percentage (see instructions)			4
5	Capital cost for comparison to payments (line 3 x line 4)			5
6	Percentage adjustment for extraordinary circumstances (see instructions)			6
7	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)			7
8	Capital minimum payment level (line 5 plus line 7)			8
9	Current year capital payments (from Part I, line 6 or Part II, line 10, as applicable)			9
10	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)			10
11	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part IV, line 14)			11
12	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)			12
13	Current year exception payment (if line 12 is positive, enter the amount on this line) for the following period (if line 12 is negative, enter the amount on this line)			13
14	Carryover of accumulated capital minimum payment level over capital payment			14
15	Current year allowable operating and capital payment (see instructions)			15
16	Current year operating and capital costs (see instructions)			16
17	Current year exception offset amount			17

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Cost Report data

420002
PIEDMONT MEDICAL CENTER
222 SOUTH HERLONG AVENUE
ROCK HILL, SC 29732

[Electronic Record Code: 6608 - 2010]
Type of Facility: Short Term Acute Care
Type of Control: Proprietary, Corporation
Classification: Urban

Bed Size:	268
Total Annual Discharges:	13,667
Total Patient Revenue:	$592,979,392

Period: 06/01/2010 - 05/31/2011
Status: As Submitted

Fiscal Intermediary: TrailBlazer Health Enterprises, LLC

Medicare Inpatient Characteristics

DSH Ratio:	0.139700
DSH Amount:	$5,876,155
Outlier Amount:	$845,448
IME Amount:	$0
GME Amount:	$0
Total IP Reimbursement:	$53,635,148
Total IP Costs:	$54,966,696
NPR Date:	00/00/0000
NPR Settlement Amount:	$48,590,615
NPR Settlement Percent:	90.59 %

[Date Generated. 03/20/2013]

Source
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Worksheet Descriptions and Formats
Please note that CostReportData.com worksheets are replicated from electronic cost report data obtained from the CMS Healthcare Cost Report Information System dataset (HCRIS) and may differ from the format submitted by the hospital (e.g. sub-lines and sub-columns may be combined, certain totals have been calculated, etc.). Also, please note that some worksheets may not be included because data are not available from the CMS HCRIS file or because the worksheets are seldom used. Cost reports for periods beginning May 1, 2010 are based on a new 2552-10 format and sometimes contain ambiguities in the assignment of some cost centers as submitted by a hospital. Whenever such ambiguities are overridden you will see an explanation at the top of all affected worksheets.

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Legend:

Identification
A hospital's Medicare provider number, name, and address are taken from Worksheet S-2. The Electronic Code is a code assigned by CostReportData.com to assist in resolving questions.

Type of Facility
The type of facility is determined from the last four digits of its Medicare provider number.

Type of Control
A hospital's type of control is taken from the HCRIS file.

Bed Size
The number of staffed beds is taken from Worksheet S-3, Part I, line 12, col.1. Cost report instructions define staffed beds as, "the number of beds available for use by patients at the end of the cost reporting period. A bed means an adult bed, pediatric bed, birthing room, or newborn bed maintained in a patient care area for lodging patients in acute, long term, or domiciliary areas of the hospital. Beds in labor room, birthing room, postanesthesia, postoperative recovery rooms, outpatient areas, emergency rooms, ancillary departments, nurses' and other staff residences, and other such areas which are regularly maintained and utilized for only a portion of the stay of patients (primarily for special procedures or not for inpatient lodging) are not termed a bed for these purposes.

Total Annual Discharges
The total number of inpatient discharges (all payors) is taken from Worksheet S-3, part I, line 12, column 15.

Total Patient Revenue
The total patient revenue (inpatient and outpatient) is taken from Worksheet G-2, part I, line 25, column 3.

Period
The beginning and ending dates for a cost report are taken from Worksheet S-2, line 17.

Status
The status of a cost report is taken from the HCRIS file.

Fiscal Intermediary
Medicare Fiscal Intermediaries (FIs) are private insurance companies that serve as the federal government's agents in the administration of the Medicare program, including the payment of claims. The name of the FI is obtained from a hospital's most recent Medicare cost report.

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Petitioner's Trial Exhibit 081B

Disproportionate Share (DSH Amount and DSH Ratio)
Medicare provides additional payment to hospitals that treat a disproportionate share of low-income patients. Qualifying hospitals receive a percentage increase in Medicare payments. This percentage increase varies depending on the ratio of low income patients and on certain statutory calculations. The Disproportionate SHare (DSH) ratio is taken from Worksheet E, Part A, line 4.03. The amount of DSH payments is from Worksheet E, Part A, line 4.04.

Outlier Amount
Medicare makes additional payments to hospitals for patients with costs that are extraordinarily high due to severity of illness and/or complicating conditions. The amount of outlier payments is from Worksheet E, Part A, line 2.01 (or line 2 for discharges occurring prior to October 1, 1997).

IME Amount
Teaching hospitals receive additional Medicare payment due to the indirect costs associated with medical education programs. These payments are intended to cover the costs of additional tests and procedures ordered by interns and residents over and above what would have been ordered by more experienced physicians. The amount of the Indirect Medical Education (IME) adjustment is from Worksheet E, Part A, line 3.24 (or line 3.03 for cost reporting periods ending on or before September 30, 1997).

GME Amount
Medicare pays a hospital for the costs of an approved direct Graduate Medical Education (GME) program. These costs include the direct cost of salaries and benefits for interns, residents, and teachers. The amount of GME payment is from Worksheet E, Part A, line 11.

Total IP Reimbursement
The total amount of Medicare inpatient reimbursement for the cost reporting period is from Worksheet E, Part A, line 16 for PPS hospitals or from Worksheet E-3, Part I, line 17 or Worksheet E-3, Part II, Line 30 for non-PPS hospitals.

Total IP Costs
Total IP Costs corresponding to Total IP Reimbursement are calculated in the cost report and summarized on Worksheet D-1, Part II, line 49.

NPR Date
At the close of its fiscal year, a provider must submit a cost report to the FI showing the costs it incurred during the fiscal year and the proportion of those costs to be allocated to Medicare. The FI reviews the cost report, determines the total amount of Medicare reimbursement due the provider and issues the provider a Notice of Program Reimbursement (NPR). The NPR date is obtained from the most recent cost report data (HCRIS). There is no NPR date for cost reports as submitted or as amended by the provider (see Status above).

NPR Settlement Amount
The NPR Settlement Amount is the Balance due provider/(Program). It is the difference between the Total IP Reimbursement (above) and the total interim payments for the cost reporting period less any tentative settlements previously made by the FI. The Balance due provider/(Program) is from Worksheet E, Part A, line 29 for PPS hospitals or from Worksheet E-3, Part I, line 20 or Worksheet E-3, Part II, Line 33 for non-PPS hospitals.

NPR Settlement Percentage
This NPR settlement percentage is the NPR settlement amount as a percentage of total inpatient reimbursement. (It is calculated from the data elements previously defined.)

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PIEDMONT MEDICAL CENTER - ROCK HILL, SC
Cost report status - As Submitted
[Record code 6608 - 2010]

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 420002	PERIOD: FROM 06/01/2010 TO 05/31/2011	WORKSHEET S PARTS I, II & III
This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).		FORM APPROVED OMB NO. 0938-0050	

PART I - COST REPORT STATUS

Provider use only	1. [X] Electronically filed cost report		Date:	Time:
	2. [ ] Manually submitted cost report			
	3. [ ] 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. [1] Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended	6. Date Received: 12/02/2011	10. NPR Date:	
		7. Contractor No.: 04101	11. Contractor's Vendor Code: 4	
		8. [N] Initial Report for this Provider CCN	12. [ ] If line 5, column 1 is 4: Enter number of times reopened = 0-9.	
		9. [N] Final Report for this Provider CCN		

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 _____{Provider Name(s) and Number(s)} for the cost reporting period beginning _____ and ending _____ and to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services identified in this cost report were provided in compliance with such laws and regulations.

(Signed)	Name NOT AVAILIABLE ON ELECTRONIC FORM
	Officer or Administrator of Provider(s)
	Title NOT AVAILIABLE ON ELECTRONIC FORM
	Title
	Date

PART III - SETTLEMENT SUMMARY

		TITLE V	TITLE XVIII		HIT	TITLE XIX	
			PART A	PART B			
		1	2	3	4	5	
1	HOSPITAL		-654,776	333,691		3,568,425	1
2	SUBPROVIDER - IPF		32,231	-48			2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF						5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY						7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC						10
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER (Specify)						12
200	TOTAL		-622,545	333,643		3,568,425	200

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 this 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 this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB 15-II, SECTIONS 4003.1-4003.3)

Rev. 2 | 40-503 - 08-11

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PIEDMONT MEDICAL CENTER - ROCK HILL, SC
Cost report status - As Submitted
[Record code 6608 - 2010]

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 420002	PERIOD: FROM 06/01/2010 TO 05/31/2011	WORKSHEET S-10	
Uncompensated and indigent care cost computation				
1	Cost to charge ratio (Worksheet C, Part I line 200 column 3 divided by line 200 column 8)		0.323246	1
Medicaid (see instructions for each line)				
2	Net revenue from Medicaid		25,891,378	2
3	Did you receive DSH or supplemental payments from Medicaid?		Y	3
4	If line 3 is yes, does line 2 include all DSH or supplemental payments from Medicaid?		N	4
5	If line 4 is no, enter DSH or supplemental payments from Medicaid		11,703,948	5
6	Medicaid charges		46,106,536	6
7	Medicaid cost (line 1 times line 6)		14,903,754	7
8	Difference between net revenue and costs for Medicaid program (line 2 plus line 5 minus line 7)			8
State Children's Health Insurance Program (SCHIP) (see instructions for each line)				
9	Net revenue from stand-alone SCHIP			9
10	Stand-alone SCHIP charges			10
11	Stand-alone SCHIP cost (line 1 times line 10)			11
12	Difference between net revenue and costs for stand-alone SCHIP (line 9 minus line 11)			12
Other state or local government indigent care program (see instructions for each line)				
13	Net revenue from state or local indigent care program (not included on lines 2, 5 or 9)			13
14	Charges for patients covered under state or local indigent care program (not included in lines 6 or 10)			14
15	State or local indigent care program cost (line 1 times line 14)			15
16	Difference between net revenue and costs for state or local indigent care program (line 13 minus line 15)			16
Uncompensated care (see instructions for each line)				
17	Private grants, donations, or endowment income restricted to funding charity care			17
18	Government grants, appropriations or transfers for support of hospital operations		57,727	18
19	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)			19

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1	2	3	
20	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	22,423,092	139,893	22,562,986	20
21	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	7,248,175	45,220	7,293,395	21
22	Partial payment by patients approved for charity care	67,604	1,540	69,144	22
23	Cost of charity care (line 21 minus line 22)	7,180,571	43,680	7,224,251	23
24	Does the amount in line 20, column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			N	24
25	If line 24 is yes, enter charges for patient days beyond an indigent care program's length of stay limit (see instructions)				25
26	Total bad debt expense for the entire hospital complex (see instructions)				26
27	Medicare bad debts for the entire hospital complex (see instructions)			1,521,017	27
28	Non-Medicare and non-reimbursable bad debt expense (line 26 minus line 27)			-1,521,017	28
29	Cost of non-Medicare bad debt expense (line 1 times line 28)			-491,663	29
30	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)			6,732,588	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			6,732,588	31

FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4012)

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PIEDMONT MEDICAL CENTER - ROCK HILL, SC
Cost report status - As Submitted
[Record code 6608 - 2010]

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 420002	PERIOD: FROM 06/01/2010 TO 05/31/2011	WORKSHEET S-2 PART I

Hospital and Hospital Health Care Complex Address:

1	Street: 222 SOUTH HERLONG AVENUE			P.O. Box:	1
2	City: ROCK HILL	State: SC	Zip Code: 29732	County: YORK	2

Hospital and Hospital-Based Component Identification:

	Component	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
	0	1	2	3	4	5	6	7	8	
3	Hospital	PIEDMONT MEDICAL CENTER	420002		1	07/01/1966	N	P	P	3
4	Subprovider- IPF	PIEDMONT MEDICAL CENTER PSYCH	42S002		4	05/01/1992	N	P	O	4
5	Subprovider- IRF									5
6	Subprovider- (Other)									6
7	Swing Beds-SNF						N	N	N	7
8	Swing Beds-NF						N		N	8
9	Hospital-Based SNF						N	N	N	9
10	Hospital-Based NF						N		N	10
11	Hospital-Based OLTC									11
12	Hospital-Based HHA						N	N	N	12
13	Separately Certified ASC						N	N	N	13
14	Hospital-Based Hospice									14
15	Hospital-Based Health Clinic-RHC						N	N	N	15
16	Hospital-Based Health Clinic-FQHC						N	N	N	16
17	Hospital-Based (CMHC)						N	N	N	17
18	Renal Dialysis									18
19	Other									19

20	Cost Reporting Period (mm/dd/yyyy)	From: 06/01/2010	To: 05/31/2011			20
21	Type of control (see instructions)	4				21

Inpatient PPS Information			
		1	2	
22	Does this facility qualify for and receive disproportionate share hospital payment in accordance with 42 CFR §412.106, or low income payment in accordance with 42 CFR §412.624 (e)(2)? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR §412.06 (e)(2) (Pickle amendment hospital)? In column 2, enter "Y" for yes or "N" for no.	Y	N	22
23	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N	23

		In-State Medicaid paid days	In-State Medicaid eligible days	Out-of State Medicaid paid days	Out-of State Medicaid eligible days	Medicaid HMO days	Other Medicaid days	
		1	2	3	4	5	6	
24	If line 22 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.	7,251	1,206	32	1	5,456		24
25	If line 22 is "yes", and this provider is an IRF then, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible days in col. 2, out-of-state Medicaid 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.							25

26	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
27	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter "1" for urban or "2" for rural.	1		27

35	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.			35
36	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	36
37	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.			37

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 420002	PERIOD: FROM 06/01/2010 TO 05/31/2011	WORKSHEET S-2 PART I	
38 Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.		Beginning:	Ending:	38

		V	XVIII	XIX	
Prospective Payment System (PPS)-Capital		1	2	3	
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320? (see instructions)	N	Y	N	45
46	Is this facility eligible for the special exceptions payment pursuant to 42 CFR §412.348(g)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N	46
47	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47
48	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48

		1	2	3	
Teaching Hospitals					
56	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56
57	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.	N			57
58	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
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59
60	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
		Y/N	IME Average	Direct GME Average	
61	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)	N			61

ACA Provisions Affecting the Health Resources and Services Administration (HRSA)				
62	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)			62
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)			62.01

Teaching Hospitals that Claim Residents in Non-Provider Settings					
63	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
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.		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
64	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)				64

	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1	2	3	4	5	
65 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)						65

Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
	1	2	3	
66 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)				66

	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1	2	3	4	5	
67 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						67

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 420002	PERIOD: FROM 06/01/2010 TO 05/31/2011		WORKSHEET S-2 PART I		
	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)						
Inpatient Psychiatric Facility PPS				1	2	3	
70	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
71	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			71
Inpatient Rehabilitation Facility PPS							
75	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes or "N" for no.			N			75
76	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)						76
Long Term Care Hospital PPS							
80	Is this a Long Term Care Hospital (LTCH)? Enter "Y" for yes or "N" for no.				N		80
TEFRA Providers							
85	Is this a new hospital under 42 CFR §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.				N		85
86	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR §413.40(f)(1)(ii)? Enter "Y" for yes or "N" for no.				N		86
					V	XIX	
Title V and XIX Inpatient Services					1	2	
90	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in applicable column.				N	Y	90
91	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	Y	91
92	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
93	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
94	Does title V or title XIX reduce capital cost? Enter "Y" for yes or "N" for no in the applicable column.				N	Y	94
95	If line 94 is "Y", enter the reduction percentage in the applicable column.					0.00	95
96	Does title V or title XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.				N	Y	96
97	If line 96 is "Y", enter the reduction percentage in the applicable column.					0.00	97
Rural Providers					1	2	
105	Does this hospital qualify as a Critical Access Hospital (CAH)?				N		105
106	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)						106
107	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
108	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR §412.113(c). Enter "Y" for yes or "N" for no.				N		108
			Physical	Occupationa	Speech	Respiratory	
109	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				109
Miscellaneous Cost Reporting Information							
115	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
116	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.				N		116
117	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.				Y		117
118	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
118.02					N		118.02
119	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.						119
120	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
121	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.				Y		121
Transplant Center Information							
125	Does this facility operate a transplant center? Enter "Y" for yes or "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.				N		125
126	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						126
127	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
128	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
129	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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 420002	PERIOD: FROM 06/01/2010 TO 05/31/2011	WORKSHEET S-2 PART I

130	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
131	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
132	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
133	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
134	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134

All Providers

		1	2	
140	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	HB0557	140

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	Name: TENET HEALTHCARE CORP		Contractor's Name: TRAILBLAZER HEALTH ENTERPRISES		Contractor's Number:	141
142	Street: 1445 ROSS AVENUE STE 1400		P.O. Box:			142
143	City: DALLAS	State TX	Zip Code: 75202-2703			143

144	Are provider based physicians' costs included in Worksheet A?	Y		144
145	If costs for renal services are claimed on Worksheet A, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.	Y		145
146	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146
147	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N		147
148	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N		148
149	Was the change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N		149

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)		Part A	Part B	Title V	Title XIX	
		1	2	3	4	
155	Hospital	N	N	N	N	155
156	Subprovider - IPF	N	N	N	N	156
157	Subprovider - IRF	N	N	N	N	157
158	Subprovider - Other					158
159	SNF	N	N	N	N	159
160	HHA	N	N	N	N	160
161	CMHC		N		N	161

Multicampus

165	Is this hospital part of a multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N		165

If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip in column 3, CBSA in column 4, FTE/Campus in column 5.

	Name	County	State	Zip Code	CBSA	FTE/ Campus	
	0	1	2	3	4	5	
166							166

Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act

167	Is this provider a meaningful user under §1886 (n)? Enter "Y" for yes or "N" for no.	N		167
168	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)			168
169	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)			169

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PIEDMONT MEDICAL CENTER - ROCK HILL, SC
Cost report status - As Submitted
[Record code 6608 - 2010]

08-11	FORM CMS-2552-10		4090 (Cont.)
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 420002	PERIOD: FROM 06/01/2010 TO 05/31/2011	WORKSHEET S-2 Part II

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

		Y/N	Date		
Provider Organization and Operation		1	2		
1	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
		Y/N	Date	V/I	
		1	2	3	
2	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
3	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
		Y/N	Type	Date	
Financial Data and Reports		1	2	3	
4	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4
5	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5
			Y/N	Y/N	
Approved Educational Activities			1	2	
6	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?		N		6
7	Are costs claimed for allied health programs? If yes, see instructions.		N		7
8	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.		N		8
9	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.		N		9
10	Was an Intern-Resident program initiated or renewed in the current cost reporting period? If yes, see instructions.		N		10
11	Are GME costs directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.		N		11
Bad Debts				Y/N	
12	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12
13	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
14	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14
Bed Complement					
15	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15

		Part A		Part B		
		Y/N	Date	Y/N	Date	
PS&R Report Data		1	2	3	4	
16	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N		16
17	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	09/30/2011	Y	09/30/2011	17
18	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 the cost report? If yes, see instructions.	N		N		18
19	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		N		19
20	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N		20
21	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21

COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)

Capital Related Cost			
22	Have assets been relifed for Medicare purposes? If yes, see instructions.	N	22
23	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23
24	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions.	N	24
25	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N	25
26	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26
27	Has the provider's capitalization policy changed during the cost reporting period? If yes, see instructions.	N	27

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08-11	FORM CMS-2552-10	4090 (Cont.)	
Interest Expense			
28	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N	28
29	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
30	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30
31	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31
Purchased Services			
32	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N	32
33	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N	33
Provider-Based Physicians			
34	Are services furnished at the provider facility under an arrangement with provider-based physicians? If "Y" see instructions.	N	34
35	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
	Y/N	Date	
Home Office Costs	1	2	
36	Are home office costs claimed on the cost report?	N	36
37	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	N	37
38	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office	N	38
39	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N	39
40	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N	40
FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB 15-II, SECTIONS 4004.2)			
40-510		Rev. 2	

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PIEDMONT MEDICAL CENTER - ROCK HILL, SC
Cost report status - As Submitted
[Record code 6608 - 2010]

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 420002 | PERIOD: FROM 06/01/2010 TO 05/31/2011 | WORKSHEET S-3 PART I

Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH Hours	Inpatient Days / Outpatient Visits / Trips				Full Time Equivalents			Discharges				
					Title V	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	
1 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	236	86,140			25,233	5,997	52,471					5,557	1,427	13,667	1
2 HMO						5,168	5,254									2
3 HMO IPF																3
4 HMO IRF																4
5 Hospital Adults & Peds. Swing Bed SNF																5
6 Hospital Adults & Peds.Swing Bed NF																6
7 Total Adults and Peds. (exclude observation beds) (see instructions)		236	86,140			25,233	5,997	52,471								7
8 Intensive Care Unit		32	11,680			2,976	395	5,250								8
9 Coronary Care Unit																9
10 Burn Intensive Care Unit																10
11 Surgical Intensive Care Unit																11
12 Other Special Care																12
13 Nursery	43.00						1,868	5,136								13
14 Total (see instructions)		268	97,820			28,209	8,260	62,857		995.11			5,557	1,427	13,667	14
15 CAH visits																15
16 Subprovider - IPF	40 00	20	7,300			1,528	1,175	5,211		18.89			170	209	870	16
17 Subprovider - IRF	41.00															17
18 Subprovider - Other	42.00															18
19 Skilled Nursing Facility	44.00															19
20 Nursing Facility	45.00															20
21 Other Long Term Care	46.00															21
22 Home Health Agency	101.00															22
23 ASC (Distinct Part)	115.00															23
24 Hospice (Distinct Part)	116.00															24
25 CMHC	99.00															25
26 RHC/FQHC (specify)	88 00															26
27 Total (sum of lines 14-26)		288								1,014.00						27
28 Observation Bed Days							260	1,878								28
28.																28
29 Ambulance Trips																29
30 Employee discount days (see instructions)																30
31 Employee discount days -IRF																31

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA				Provider CCN: 420002	PERIOD: FROM 06/01/2010 TO 05/31/2011	WORKSHEET S-3 PART I	
32	Labor & delivery days (see instructions)	432	586				32
33	LTCH non-covered days						33
FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4005.1)							
Rev. 2							40-511 - 08-11

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PIEDMONT MEDICAL CENTER - ROCK HILL, SC
Cost report status - As Submitted
[Record code 6608 - 2010]

HOSPITAL WAGE INDEX INFORMATION	Provider CCN: 420002	PERIOD: FROM 06/01/2010 TO 05/31/2011	WORKSHEET S-3 PART II

Part II - Wage Data

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (column 2 ± column 3)	Paid Hours Related to Salaries in column 4	Average Hourly Wage (column 4 ÷ column 5)	
		1	2	3	4	5	6	
SALARIES								
1	Total salaries (see instructions)	200	64,632,056		64,632,056	2,380,407	** 27.15	1
2	Non-physician anesthetist Part A							2
3	Non-physician anesthetist Part B							3
4	Physician-Part A							4
5	Physician-Part B		47,862		47,862	959	** 49.91	5
6	Non-physician-Part B							6
7	Interns & residents (in an approved program)	21						7
8	Home office personnel							8
9	SNF	44						9
10	Excluded area salaries (see instructions)		7,079,926	1,033	7,080,959	312,973	** 22.62	10
OTHER WAGES AND RELATED COSTS								
11	Contract labor (see instructions)		2,562,562		2,562,562	40,094	** 63.91	11
12	Management and administrative services							12
13	Contract labor: physician-Part A							13
14	Home office salaries & wage-related costs		7,713,134		7,713,134	154,610	** 49.89	14
15	Home office: physician Part A							15
16	Teaching physician salaries (see instructions)							16
WAGE-RELATED COSTS								
17	Wage-related costs (core) Worksheet S-3, Part IV line 24		14,104,234		14,104,234			17
18	Wage-related costs (other) Worksheet S-3, Part IV line 25							18
19	Excluded areas		1,730,332		1,730,332			19
20	Non-physician anesthetist Part A							20
21	Non-physician anesthetist Part B							21
22	Physician Part A							22
23	Physician Part B		17,017		17,017			23
24	Wage-related costs (RHC/FQHC)							24
25	Interns & residents (in an approved program)							25
OVERHEAD COSTS - DIRECT SALARIES								
26	Employee Benefits	4	807,085		807,085	37,275	** 21.65	26
27	Administrative & General	5	5,862,827	-63,729	5,799,098	181,686	** 31.92	27
28	Administrative & General under contract (see instructions)		293,258		293,258	2,049	** 143.12	28
29	Maintenance & Repairs	6						29
30	Operation of Plant	7	657,121		657,121	30,899	** 21.27	30
31	Laundry & Linen Service	8						31
32	Housekeeping	9						32
33	Housekeeping under contract (see instructions)							33
34	Dietary	10						34
35	Dietary under contract (see instructions)							35
36	Cafeteria	11						36
37	Maintenance of Personnel	12						37
38	Nursing Administration	13	1,815,399		1,815,399	41,958	** 43.27	38
39	Central Services and Supply	14	481,250		481,250	37,189	** 12.94	39
40	Pharmacy	15	2,540,091		2,540,091	67,429	** 37.67	40
41	Medical Records & Medical Records Library	16	1,784,629		1,784,629	87,880	** 20.31	41
42	Social Service	17						42
43	Other General Service	18						43

Part III - Hospital Wage Index Summary

1	Net salaries (see instructions)		64,877,456		64,877,456	2,381,497	** 27.24	1
2	Excluded area salaries (see instructions)		7,079,926	1,033	7,080,959	312,973	** 22.62	2
3	Subtotal salaries (line 1 minus line 2)		57,797,528	-1,033	57,796,496	2,068,524	** 27.94	3

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HOSPITAL WAGE INDEX INFORMATION			Provider CCN: 420002		PERIOD: FROM 06/01/2010 TO 05/31/2011		WORKSHEET S-3 PART II	
4	Subtotal other wages and related costs (see instructions)	[redacted]	10,275,696		10,275,696	194,704	** 52.78	4
5	Subtotal wage-related costs (see instructions)	[redacted]	14,104,234		14,104,234			5
6	Total (sum of lines 3 through 5)	[redacted]			82,176,424			6
7	Total overhead cost (see instructions)	[redacted]	14,241,660	-63,729	14,177,931	486,365	** 29.15	7
FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4005.2 - 4005.3)								
Rev. 2							40-513 - 08-11	

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HOSPITAL WAGE RELATED COSTS	Provider CCN: 420002	PERIOD: FROM 06/01/2010 TO 05/31/2011	WORKSHEET S-3, PART IV

Part IV - Wage Related Cost

Part A - Core List

		Amount Reported	
RETIREMENT COST			
1	401k Employer Contributions	509,898	1
2	Tax Sheltered Annuity (TSA) Employer Contribution		2
3	Qualified and Non-Qualified Pension Plan Cost		3
4	Prior Year Pension Service Cost		4
PLAN ADMINISTRATIVE COSTS (Paid to External Organization):			
5	401k/TSA Plan Administration fees		5
6	Legal/Accounting/Management Fees-Pension Plan		6
7	Employee Managed Care Program Administration Fees		7
HEALTH AND INSURANCE COST			
8	Health Insurance (Purchased or Self Funded)	7,638,889	8
9	Prescription Drug Plan		9
10	Dental, Hearing and Vision Plan		10
11	Life Insurance (If employee is owner or beneficiary)		11
12	Accident Insurance (If employee is owner or beneficiary)		12
13	Disability Insurance (If employee is owner or beneficiary)		13
14	Long-Term Care Insurance (If employee is owner or beneficiary)		14
15	Workers' Compensation Insurance	874,037	15
16	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		16
TAXES			
17	FICA-Employers Portion Only	4,657,254	17
18	Medicare Taxes - Employers Portion Only		18
19	Unemployment Insurance	114,680	19
20	State or Federal Unemployment Taxes	216,169	20
OTHER			
21	Executive Deferred Compensation		21
22	Day Care Cost and Allowances		22
23	Tuition Reimbursement	93,307	23
24	Total Wage Related cost (Sum of lines 1 -23)	14,104,234	24

Part B - Other than Core Related Cost

25	Other Wage Related Costs (specify)_____		25

FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4005.4)

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HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provider CCN: 420002	PERIOD: FROM 06/01/2010 TO 05/31/2011	WORKSHEET S-3, PART V

Part V - Contract Labor and Benefit Cost
Hospital and Hospital-Based Component Identification:

	Component	Contract Labor	Benefit Cost	
	0	1	2	
1	Total facility contract labor and benefit cost	2,681,214		1
2	Hospital	2,562,562		2
3	Subprovider- IPF	118,652		3
4	Subprovider- IRF			4
5	Subprovider- (Other)			5
6	Swing Beds-SNF			6
7	Swing Beds-NF			7
8	Hospital-Based SNF			8
9	Hospital-Based NF			9
10	Hospital-Based OLTC			10
11	Hospital-Based HHA			11
12	Separately Certified ASC			12
13	Hospital-Based Hospice			13
14	Hospital-Based Health Clinic RHC			14
15	Hospital-Based Health Clinic FQHC			15
16	Hospital-Based-CMHC			16
17	Renal Dialysis			17
18	Other			18

FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4005.5)

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PIEDMONT MEDICAL CENTER - ROCK HILL, SC
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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES			Provider CCN: 420002			PERIOD: FROM 06/01/2010 TO 05/31/2011		WORKSHEET A	
		COST CENTER DESCRIPTIONS (omit cents)	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	RECLASSIFIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	Capital Related Costs-Buildings and Fixtures		3,265,303	3,265,303	1,487,636	4,752,939	1,433,552	6,186,491	1
2	00200	Capital Related Costs-Movable Equipment		7,094,924	7,094,924	2,672,463	9,767,387	-1,379,599	8,387,788	2
3	00300	Other Capital Related Costs		10,197,975	10,197,975	-10,197,975			-0-	3
4	00400	Employee Benefits	807,085	889,708	1,696,793	-49,850	1,646,943	-75	1,646,868	4
5	00500	Administrative and General	5,862,827	38,697,760	44,560,584	6,370,922	50,931,508	-5,460,926	45,470,580	5
6	00600	Maintenance and Repairs								6
7	00700	Operation of Plant	657,121	6,036,382	6,693,503	-2,923	6,690,580	-30,319	6,660,261	7
8	00800	Laundry and Linen Service		179,137	179,137	809,991	989,128		989,128	8
9	00900	Housekeeping		2,229,506	2,229,506	-21,178	2,208,328		2,208,328	9
10	01000	Dietary		2,454,893	2,454,893	-1,966,773	488,120		488,120	10
11	01100	Cafeteria				1,443,419	1,443,419	-481	1,442,938	11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	1,815,399	591,600	2,406,999	-8,790	2,398,209	-16,054	2,382,155	13
14	01400	Central Services and Supply	481,250	747,571	1,228,821	-131,068	1,097,753		1,097,753	14
15	01500	Pharmacy	2,540,091	7,746,466	10,286,557	-7,157,964	3,128,593	-23	3,128,570	15
16	01600	Medical Records & Medical Records Library	1,784,629	1,531,231	3,315,860	-4,392	3,311,468	-65	3,311,403	16
17	01700	Social Service								17
18		Other General Service (specify)								18
19	01900	Nonphysician Anesthetists								19
20	02000	Nursing School								20
21	02100	Intern & Res Service-Salary & Fringes (Approved)								21
22	02200	Intern & Res. Other Program Costs (Approved)								22
23	02300	Paramedical Ed. Program (specify)								23
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults and Pediatrics (General Routine Care)	16,148,189	7,123,864	23,272,052	-1,158,490	22,113,564	-698,527	21,415,036	30
31	03100	Intensive Care Unit	3,398,036	2,270,705	5,668,741	-357,715	5,311,026	-756,233	4,554,793	31
32	03200	Coronary Care Unit								32
33	03300	Burn Intensive Care Unit								33
34	03400	Surgical Intensive Care Unit								34
35		Other Special Care (specify)								35
40	04000	Subprovider - IPF	1,406,723	554,099	1,960,822	-126,698	1,834,124	-31,905	1,802,219	40
41	04100	Subprovider - IRF								41
42	04200	Subprovider (specify)								42

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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES			Provider CCN: 420002				PERIOD: FROM 06/01/2010 TO 05/31/2011		WORKSHEET A	
COST CENTER DESCRIPTIONS (omit cents)			SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	RECLASSIFIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
43	04300	Nursery	1,022,573	596,729	1,619,302	-147,651	1,471,651	-176,908	1,294,743	43
44	04400	Skilled Nursing Facility								44
45	04500	Nursing Facilty								45
46	04600	Other Long Term Care								46
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	5,498,071	11,987,108	17,485,180	-9,931,461	7,553,718	-17,332	7,536,386	50
51	05100	Recovery Room								51
52	05200	Labor Room and Delivery Room	1,602,576	792,064	2,394,640	-327,922	2,066,718		2,066,718	52
53	05300	Anesthesiology								53
54	05400	Radiology-Diagnostic	3,308,794	3,814,509	7,123,303	-1,489,959	5,633,344	-495	5,632,849	54
55	05500	Radiology-Therapeutic								55
56	05600	Radioisotope								56
57	05700	Computed Tomography (CT) Scan								57
58	05800	Magnetic Resonance Imaging (MRI)	193,083	65,275	258,358	-16,257	242,101		242,101	58
59	05900	Cardiac Catheterization								59
60	06000	Laboratory	2,881,366	6,222,471	9,103,837	-98,742	9,005,095	-354,236	8,650,859	60
60.45	06000	Vascular Lab	1,301,903	7,694,194	8,996,097	-6,927,936	2,068,161		2,068,161	60.45
61	06100	PBP Clinical Laboratory Services-Program Only								61
62	06200	Whole Blood & Packed Red Blood Cells								62
63	06300	Blood Storing, Processing, & Trans.								63
64	06400	Intravenous Therapy	189,739	1,210,693	1,400,432	637,999	2,038,431	-107	2,038,324	64
65	06500	Respiratory Therapy	1,477,639	1,035,897	2,513,536	-613,976	1,899,560	-138	1,899,422	65
66	06600	Physical Therapy	817,928	311,720	1,129,648	-10,764	1,118,884		1,118,884	66
67	06700	Occupational Therapy	83,350	23,694	107,044	-7,666	99,378		99,378	67
68	06800	Speech Pathology	111,812	22,717	134,529	-1,960	132,569		132,569	68
69	06900	Electrocardiology	620,561	281,795	902,356	-7,976	894,380		894,380	69
70	07000	Electroencephalography	78,019	431,365	509,384	-3,617	505,767		505,767	70
71	07100	Medical Supplies Charged to Patients				9,751,131	9,751,131		9,751,131	71
72	07200	Implantable Devices Charged to Patients				10,283,466	10,283,466		10,283,466	72
73	07300	Drugs Charged to Patients				7,405,735	7,405,735		7,405,735	73
74	07400	Renal Dialysis		414,394	414,394	-18,037	396,357		396,357	74
75	07500	ASC (Non-Distinct Part)								75
76		Other Ancillary (specify)								76
76 30		Other Ancillary Cost Centers	1,068,003	1,515,538	2,583,541	-757,488	1,826,053	-6,250	1,819,803	76.30
		OUTPATIENT SERVICE COST CENTERS								
88	08800	Rural Health Clinic (RHC)								88
89	08900	Federally Qualified Health Center (FQHC)								89

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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES			Provider CCN: 420002		PERIOD: FROM 06/01/2010 TO 05/31/2011			WORKSHEET A	
		COST CENTER DESCRIPTIONS (omit cents)	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	RECLASSIFIED TRIAL BALANCE (col 3 ± col. 4)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col 5 ± col. 6)	
			1	2	3	4	5	6	7	
90	09000	Clinic	504,810	765,020	1,269,830	-178,431	1,091,399	-127,555	963,844	90
91	09100	Emergency	3,297,278	4,207,642	7,504,920	-462,637	7,042,283	-1,297,458	5,744,825	91
92	09200	Observation Beds								92
93		Other Outpatient Service (specify)								93
		OTHER REIMBURSABLE COST CENTERS								
94	09400	Home Program Dialysis								94
95	09500	Ambulance Services	5,516,335	2,731,232	8,247,567	-195,729	8,051,838	-40	8,051,798	95
96	09600	Durable Medical Equipment-Rented								96
97	09700	Durable Medical Equipment-Sold								97
98		Other Reimbursable (specify)								98
99		Outpatient Rehabilitation Provider (specify)								99
100	10000	Intern-Resident Service (not apprvd. tchng. prgm.)								100
101	10100	Home Health Agency								101
		SPECIAL PURPOSE COST CENTERS								
105	10500	Kidney Acquisition								105
106	10600	Heart Acquisition								106
107	10700	Liver Acquisition								107
108	10800	Lung Acquisition								108
109	10900	Pancreas Acquisition								109
110	11000	Intestinal Acquisition								110
111	11100	Islet Acquisition								111
112		Other Organ Acquisition (specify)								112
113	11300	Interest Expense		11,252,671	11,252,671	87,319	11,339,990	-11,339,990	- 0 -	113
114	11400	Utilization Review-SNF							- 0 -	114
115	11500	Ambulatory Surgical Center (Distinct Part)								115
116	11600	Hospice								116
117		Other Special Purpose (specify)								117
118		SUBTOTALS (sum of lines 1-117)	64,475,192	146,987,856	211,463,040	-1,431,944	210,031,104	-20,261,164	189,769,936	118
		NONREIMBURSABLE COST CENTERS								
190	19000	Gift, Flower, Coffee Shop, & Canteen								190
191	19100	Research								191
192	19200	Physicians' Private Offices								192
193	19300	Nonpaid Workers								193
194		Other Nonreimbursable (specify)	156,868	618,209	775,077	1,431,944	2,207,021		2,207,021	194
200		TOTAL (sum of lines 118-199)	64,632,056	147,606,064	212,238,112	- 0 -	212,238,112	-20,261,164	191,976,960	200
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RECLASSIFICATIONS	Provider CCN: 420002	PERIOD: FROM 06/01/2010 TO 05/31/2011	WORKSHEET A-6

I - NEONATAL ANCILLARY EXPENSE

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	INCREASES				DECREASES				Wkst A-7 Ref	
			COST CENTER	LINE #	SALARY	OTHER	COST CENTER	LINE #	SALARY	OTHER		
		1	2	3	4	5	6	7	8	9	10	
1	NEONATAL ANCILLARY EXPENSE RECLASS	I		30.00	8,544	4,986		43.00	8,544	4,986		1
2												2
3												3
4												4
5												5
6												6
7												7
8												8
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22												22
23												23
24												24
25												25
26												26
27												27
28												28
29												29
500	Total reclassifications (sum of columns 4 and 5 must equal sum of columns 8 and 9)				8,544	4,986			8,544	4,986		500

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.

Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.

FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4014)

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PIEDMONT MEDICAL CENTER - ROCK HILL, SC
Cost report status - As Submitted
[Record code 6608 - 2010]

RECLASSIFICATIONS	Provider CCN: 420002	PERIOD: FROM 06/01/2010 TO 05/31/2011	WORKSHEET A-6

G - RECLASS HIGH COST IMPLANTA

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	INCREASES				DECREASES				Wkst A-7 Ref.	
			COST CENTER	LINE #	SALARY	OTHER	COST CENTER	LINE #	SALARY	OTHER		
		1	2	3	4	5	6	7	8	9	10	
1	RECLASS HIGH COST IMPLANTABLE DEVICE	G		72.00		10,283,466		71.00		10,283,466		1
2												2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21												21
22												22
23												23
24												24
25												25
26												26
27												27
28												28
29												29
500	Total reclassifications (sum of columns 4 and 5 must equal sum of columns 8 and 9)					10,283,466				10,283,466		500

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.

Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate

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RECLASSIFICATIONS	Provider CCN. 420002	PERIOD: FROM 06/01/2010 TO 05/31/2011	WORKSHEET A-6

D - RECLASS OF OTHER COC COSTS

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	INCREASES				DECREASES				Wkst. A-7 Ref.	
			COST CENTER	LINE #	SALARY	OTHER	COST CENTER	LINE #	SALARY	OTHER		
		1	2	3	4	5	6	7	8	9	10	
1	RECLASS OF OTHER COC COSTS	D		5.00		7,439,656		3.00		7,439,656		1
2												2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
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20												20
21												21
22												22
23												23
24												24
25												25
26												26
27												27
28												28
29												29
500	Total reclassifications (sum of columns 4 and 5 must equal sum of columns 8 and 9)					7,439,656				7,439,656		500

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.

Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate

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RECLASSIFICATIONS	Provider CCN: 420002	PERIOD: FROM 06/01/2010 TO 05/31/2011	WORKSHEET A-6

E - RECLASS OFFEROR/VENDOR REB

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	INCREASES				DECREASES				Wkst. A-7 Ref.	
			COST CENTER	LINE #	SALARY	OTHER	COST CENTER	LINE #	SALARY	OTHER		
		1	2	3	4	5	6	7	8	9	10	
1	RECLASS OFFEROR/VENDOR REBATES	E		14.00		128,090		71.00		128,090		1
2	RECLASS OFFEROR/VENDOR REBATES	E		15.00		209,093		73 00		209,093		2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21												21
22												22
23												23
24												24
25												25
26												26
27												27
28												28
29												29
500	Total reclassifications (sum of columns 4 and 5 must equal sum of columns 8 and 9)					337,183				337,183		500

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.

Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.

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RECLASSIFICATIONS	Provider CCN 420002	PERIOD: FROM 06/01/2010 TO 05/31/2011	WORKSHEET A-6

W - RECLASS OF RENTAL/LEASE EQ

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	INCREASES				DECREASES				Wkst. A-7 Ref.	
			COST CENTER	LINE #	SALARY	OTHER	COST CENTER	LINE #	SALARY	OTHER		
		1	2	3	4	5	6	7	8	9	10	
1	RECLASS OF RENTAL/LEASE EQUIP	W		2.00		1,401,780		4.00		4,490	10	1
2	RECLASS OF RENTAL/LEASE EQUIP	W		15.00		23,281		5.00		53,714		2
3	RECLASS OF RENTAL/LEASE EQUIP	W		69.00		1,977		7.00		876		3
4	RECLASS OF RENTAL/LEASE EQUIP	W		69.02		250,592		9.00		479		4
5	RECLASS OF RENTAL/LEASE EQUIP	W						10.00		406		5
6	RECLASS OF RENTAL/LEASE EQUIP	W						13.00		6,522		6
7	RECLASS OF RENTAL/LEASE EQUIP	W						14.00		230,868		7
8	RECLASS OF RENTAL/LEASE EQUIP	W						16.00		4,351		8
9	RECLASS OF RENTAL/LEASE EQUIP	W						30.00		159,605		9
10	RECLASS OF RENTAL/LEASE EQUIP	W						31.00		49,898		10
11	RECLASS OF RENTAL/LEASE EQUIP	W						40.00		16,286		11
12	RECLASS OF RENTAL/LEASE EQUIP	W						43.00		11,607		12
13	RECLASS OF RENTAL/LEASE EQUIP	W						50.00		64,940		13
14	RECLASS OF RENTAL/LEASE EQUIP	W						52.00		11,321		14
15	RECLASS OF RENTAL/LEASE EQUIP	W						54.00		736,236		15
16	RECLASS OF RENTAL/LEASE EQUIP	W						60.00		5,475		16
17	RECLASS OF RENTAL/LEASE EQUIP	W						65.00		255,855		17
18	RECLASS OF RENTAL/LEASE EQUIP	W						66.00		1,481		18
19	RECLASS OF RENTAL/LEASE EQUIP	W						76.26		3,228		19
20	RECLASS OF RENTAL/LEASE EQUIP	W						76.31		146		20
21	RECLASS OF RENTAL/LEASE EQUIP	W						76.32		1,178		21
22	RECLASS OF RENTAL/LEASE EQUIP	W						76.33		2,821		22
23	RECLASS OF RENTAL/LEASE EQUIP	W						90.00		3,903		23
24	RECLASS OF RENTAL/LEASE EQUIP	W						91.00		33,333		24
25	RECLASS OF RENTAL/LEASE EQUIP	W						95.00		18,611		25
26												26
27												27
28												28
29												29
500	Total reclassifications (sum of columns 4 and 5 must equal sum of columns 8 and 9)					1,677,630				1,677,630		500

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.

Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate

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RECLASSIFICATIONS	Provider CCN: 420002	PERIOD: FROM 06/01/2010 TO 05/31/2011	WORKSHEET A-6

C - RECLASS OF NON INTERCOMPAN

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	INCREASES				DECREASES				Wkst. A-7 Ref.	
			COST CENTER	LINE #	SALARY	OTHER	COST CENTER	LINE #	SALARY	OTHER		
		1	2	3	4	5	6	7	8	9	10	
1	RECLASS OF NON INTERCOMPANY INTEREST	C		113.00		87,319		5.00		87,319		1
2												2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
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19												19
20												20
21												21
22												22
23												23
24												24
25												25
26												26
27												27
28												28
29												29
500	Total reclassifications (sum of columns 4 and 5 must equal sum of columns 8 and 9)					87,319				87,319		500

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.

Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate

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RECLASSIFICATIONS	Provider CCN: 420002	PERIOD: FROM 06/01/2010 TO 05/31/2011	WORKSHEET A-6

Y - CHARGEABLE DRUGS PER G/L

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	INCREASES				DECREASES				Wkst. A-7 Ref.	
			COST CENTER	LINE #	SALARY	OTHER	COST CENTER	LINE #	SALARY	OTHER		
		1	2	3	4	5	6	7	8	9	10	
1	CHARGEABLE DRUGS PER G/L	Y		14.00		513		4.00		43,256		1
2	CHARGEABLE DRUGS PER G/L	Y		73.00		7,614,828		5.00		17,989		2
3	CHARGEABLE DRUGS PER G/L	Y						7.00		27		3
4	CHARGEABLE DRUGS PER G/L	Y						13.00		1,493		4
5	CHARGEABLE DRUGS PER G/L	Y						15.00		7,355,575		5
6	CHARGEABLE DRUGS PER G/L	Y						30.00		1,662		6
7	CHARGEABLE DRUGS PER G/L	Y						31.00		194		7
8	CHARGEABLE DRUGS PER G/L	Y						40.00		7		8
9	CHARGEABLE DRUGS PER G/L	Y						43.00		4		9
10	CHARGEABLE DRUGS PER G/L	Y						50.00		1,749		10
11	CHARGEABLE DRUGS PER G/L	Y						52.00		1,599		11
12	CHARGEABLE DRUGS PER G/L	Y						54.00		62,495		12
13	CHARGEABLE DRUGS PER G/L	Y						60.00		16,768		13
14	CHARGEABLE DRUGS PER G/L	Y						64.00		22,231		14
15	CHARGEABLE DRUGS PER G/L	Y						65.00		5,736		15
16	CHARGEABLE DRUGS PER G/L	Y						66.00		80		16
17	CHARGEABLE DRUGS PER G/L	Y						68.00		1,060		17
18	CHARGEABLE DRUGS PER G/L	Y						69.02		6		18
19	CHARGEABLE DRUGS PER G/L	Y						74.00		310		19
20	CHARGEABLE DRUGS PER G/L	Y						76.26		2,838		20
21	CHARGEABLE DRUGS PER G/L	Y						76.29		12		21
22	CHARGEABLE DRUGS PER G/L	Y						76.32		3,761		22
23	CHARGEABLE DRUGS PER G/L	Y						76.33		56,094		23
24	CHARGEABLE DRUGS PER G/L	Y						90.00		389		24
25	CHARGEABLE DRUGS PER G/L	Y						91.00		3,354		25
26	CHARGEABLE DRUGS PER G/L	Y						95.00		16,652		26
27												27
28												28
29												29
500	Total reclassifications (sum of columns 4 and 5 must equal sum of columns 8 and 9)					7,615,341				7,615,341		500

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.

Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.

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RECLASSIFICATIONS	Provider CCN: 420002	PERIOD: FROM 06/01/2010 TO 05/31/2011	WORKSHEET A-6

K - PSYCH THERAPY (OTHER)

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	INCREASES				DECREASES				Wkst. A-7 Ref.	
			COST CENTER	LINE #	SALARY	OTHER	COST CENTER	LINE #	SALARY	OTHER		
		1	2	3	4	5	6	7	8	9	10	
1	PSYCH THERAPY (OTHER)	K		76.29	62,696	28,032		40.00	62,696	28,032		1
2												2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
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16												16
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19												19
20												20
21												21
22												22
23												23
24												24
25												25
26												26
27												27
28												28
29												29
500	Total reclassifications (sum of columns 4 and 5 must equal sum of columns 8 and 9)				62,696	28,032			62,696	28,032		500

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.

Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate

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RECLASSIFICATIONS	Provider CCN: 420002	PERIOD: FROM 06/01/2010 TO 05/31/2011	WORKSHEET A-6

J - RECLASS PSYCH THERAPY (OTH

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	INCREASES				DECREASES				Wkst. A-7 Ref.	
			COST CENTER	LINE #	SALARY	OTHER	COST CENTER	LINE #	SALARY	OTHER		
		1	2	3	4	5	6	7	8	9	10	
1	RECLASS PSYCH THERAPY (OTHER)	J		40.00		12		76.29		12		1
2												2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
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16												16
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20												20
21												21
22												22
23												23
24												24
25												25
26												26
27												27
28												28
29												29
500	Total reclassifications (sum of columns 4 and 5 must equal sum of columns 8 and 9)					12				12		500

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.

Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate

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RECLASSIFICATIONS	Provider CCN: 420002	PERIOD: FROM 06/01/2010 TO 05/31/2011	WORKSHEET A-6

Z - CHARGEABLE IV SOLUTIONS PE

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	INCREASES				DECREASES				Wkst. A-7 Ref.	
			COST CENTER	LINE #	SALARY	OTHER	COST CENTER	LINE #	SALARY	OTHER		
		1	2	3	4	5	6	7	8	9	10	
1	CHARGEABLE IV SOLUTIONS PER G/L	Z		5.00		1,730		7.00		10		1
2	CHARGEABLE IV SOLUTIONS PER G/L	Z		64.00		662,413		13.00		338		2
3	CHARGEABLE IV SOLUTIONS PER G/L	Z						14.00		6,013		3
4	CHARGEABLE IV SOLUTIONS PER G/L	Z						15.00		28,506		4
5	CHARGEABLE IV SOLUTIONS PER G/L	Z						30.00		170,821		5
6	CHARGEABLE IV SOLUTIONS PER G/L	Z						31.00		47,428		6
7	CHARGEABLE IV SOLUTIONS PER G/L	Z						40.00		13		7
8	CHARGEABLE IV SOLUTIONS PER G/L	Z						43.00		14,325		8
9	CHARGEABLE IV SOLUTIONS PER G/L	Z						50.00		104,097		9
10	CHARGEABLE IV SOLUTIONS PER G/L	Z						52.00		21,427		10
11	CHARGEABLE IV SOLUTIONS PER G/L	Z						54.00		26,464		11
12	CHARGEABLE IV SOLUTIONS PER G/L	Z						58.00		1,168		12
13	CHARGEABLE IV SOLUTIONS PER G/L	Z						60.00		720		13
14	CHARGEABLE IV SOLUTIONS PER G/L	Z						65.00		2,868		14
15	CHARGEABLE IV SOLUTIONS PER G/L	Z						66.00		66		15
16	CHARGEABLE IV SOLUTIONS PER G/L	Z						69.00		210		16
17	CHARGEABLE IV SOLUTIONS PER G/L	Z						69.02		23,607		17
18	CHARGEABLE IV SOLUTIONS PER G/L	Z						74.00		748		18
19	CHARGEABLE IV SOLUTIONS PER G/L	Z						76.26		87		19
20	CHARGEABLE IV SOLUTIONS PER G/L	Z						76.32		23,620		20
21	CHARGEABLE IV SOLUTIONS PER G/L	Z						76.33		783		21
22	CHARGEABLE IV SOLUTIONS PER G/L	Z						91.00		148,508		22
23	CHARGEABLE IV SOLUTIONS PER G/L	Z						95.00		42,316		23
24												24
25												25
26												26
27												27
28												28
29												29
500	Total reclassifications (sum of columns 4 and 5 must equal sum of columns 8 and 9)					664,143				664,143		500

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.

Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.

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