

**ST. VINCENT DUNN HOSPITAL
BEDFORD, INDIANA**

PROVIDER NO. 15-1335 AND AIM NO. 100268040A

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

JUNE 30, 2011

ST. VINCENT DUNN HOSPITAL
PROVIDER NO. 15-1335 AND AIM NO. 100268040A

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Accountants' Disclaimer

Hospital Statements of Reimbursable Costs



Board of Directors
St. Vincent Dunn Hospital
Bedford, Indiana

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

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

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

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

Bradley Associates

January 26, 2012

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 151335	Period: From 07/01/2010 To 06/30/2011	Worksheet 5 Parts I-III Date/Time Prepared: 1/31/2012 9:02 am
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PART I - COST REPORT STATUS

Provider use only	1. <input type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 1/31/2012 Time: 9:02 am
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

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

Encryption Information

ECR: Date: 1/31/2012 Time: 9:02 am
AucIGQeVH52p.9gTbkaru9jF1mCt0
fuoon0n5oUpEc0wvyqP.BBnSJUD02b
YZid0VeC4o0We281
PI: Date: 1/31/2012 Time: 9:02 am
ija1EXE:BoJDMpnrJHKhChm7fpw010
u2q:u0FjcJU.PhfBgt245Nx:sI6ov1
1zR1Fv5Sm30FRPTm

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

Title

Date

	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	377,167	391,480	0	0 1.00
2.00	Subprovider - IPF	0	0	0	0	0 2.00
3.00	Subprovider - IRF	0	0	0	0	0 3.00
4.00	SUBPROVIDER I	0	0	0	0	0 4.00
5.00	Swing bed - SNF	0	0	0	0	0 5.00
6.00	Swing bed - NF	0	0	0	0	0 6.00
7.00	Skilled Nursing Facility	0	0	0	0	0 7.00
8.00	Nursing Facility	0	0	0	0	0 8.00
9.00	HOME HEALTH AGENCY I	0	0	0	0	0 9.00
10.00	RURAL HEALTH CLINIC I	0	0	0	0	0 10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0	0	0	0	0 11.00
12.00	CMHC I	0	0	0	0	0 12.00
200.00	Total	0	377,167	391,480	0	0 200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151335		Period: From 07/01/2010 To 06/30/2011		Worksheet S-2 Part I Date/Time Prepared: 1/30/2012 5:43 pm					
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 1616 TWENTY-THIRD STREET		PO Box:								
2.00	City: BEDFORD		State: IN		Zip Code: 47421		County: LAWRENCE				
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00		
Hospital and Hospital-Based Component Identification:											
3.00	Hospital		DUNN MEMORIAL HOSPITAL	151335	99915	1	07/01/1966	N	O	O	
4.00	Subprovider - IPF										
5.00	Subprovider - IRF										
6.00	Subprovider - (Other)										
7.00	Swing Beds - SNF						N	N	N		
8.00	Swing Beds - NF						N	N	N		
9.00	Hospital-Based SNF						N	N	N		
10.00	Hospital-Based NF										
11.00	Hospital-Based OLTC										
12.00	Hospital-Based HHA										
13.00	Separately Certified ASC						N	N	N		
14.00	Hospital-Based Hospice										
15.00	Hospital-Based Health Clinic - RHC										
16.00	Hospital-Based Health Clinic - FQHC										
17.00	Hospital-Based (CMHC) 1										
18.00	Renal Dialysis										
19.00	Other										
						From:	To:				
						1.00	2.00				
20.00	Cost Reporting Period (mm/dd/yyyy)					07/01/2010	06/30/2011		20.00		
21.00	Type of Control (see instructions)					2			21.00		
Inpatient PPS Information											
22.00	Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N		N		22.00	
23.00	Indicate in column 1 the method used to capture Medicaid (title XIX) days reported on lines 24 and/or 25 of this worksheet during the cost reporting period by entering a "1" if days are based on the date of admission, "2" if days are based on census days (also referred to as the day count), or "3" if the days are based on the date of discharge. Is the method of identifying the days in the current cost reporting period different from the method used in the prior cost reporting period? Enter in column 2 "Y" for yes or "N" for no.					2		N		23.00	
		In-State Medicaid paid days	In-State Medicaid eligible days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible days	Medicaid HMO days	Other Medicaid days				
		1.00	2.00	3.00	4.00	5.00	6.00				
24.00	If line 22 and/or line 45 is "yes", and this provider is an IPPS hospital enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible days in col. 4, Medicaid HMO days in col. 5, and other Medicaid days in col. 6.		0	0	0	0	0	0	0	24.00	
25.00	If this provider is an IRF, enter the in-State Medicaid paid days in column 1, the in State Medicaid eligible days in column 2, the out of State Medicaid paid days in column 3, the out of State Medicaid eligible days in column 4, Medicaid HMO days in column 5, and other Medicaid days in column 6. For all columns include in these days the labor and delivery days.		0	0	0	0	0	0	0	25.00	
									1.00		
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter (1) for urban or (2) for rural.									2	26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period? Enter (1) for urban or (2) for rural.									2	27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.									0	35.00
						Beginning:	Ending:				
						1.00	2.00				
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.										36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.							0			37.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151335	Period: From 07/01/2010 To 06/30/2011	Worksheet S-2 Part I Date/Time Prepared: 1/30/2012 5:43 pm		
		Beginning: 1.00	Ending: 2.00			
		V 1.00	XVIII 2.00	XIX 3.00		
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.					38.00
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N		45.00
46.00	Is this facility eligible for the special exceptions payment pursuant to 42 CFR Section §412.348(g)? If yes, complete worksheet L, Part III and L-1, Parts I through III	N	N	N		46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N		47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N				56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete worksheet E-4. If column 2 is "N", complete worksheet D, Part III & IV and D-2, Part II, if applicable.					57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete worksheet D-5.					58.00
59.00	Are costs claimed on line 100 of worksheet A? If yes, complete worksheet D-2, Part I.	N				59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N				60.00
		Y/N 1.00	IME Average 2.00	Direct GME Average 3.00		
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)	N	0.00	0.00		61.00
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00				62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00				62.01
Teaching Hospitals that Claim Residents in Non-Provider Settings						
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete lines 64-67. (see instructions)	N				63.00
		Unweighted FTEs Nonprovider Site 1.00	Unweighted FTEs in Hospital 2.00	Ratio (col. 1/ (col. 1 + col. 2)) 3.00		
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000		64.00
		Program Name 1.00	Program Code 2.00	Unweighted FTEs Nonprovider Site 3.00	Unweighted FTEs in Hospital 4.00	Ratio (col. 3/ (col. 3 + col. 4)) 5.00
65.00	Enter in column 1 the program name. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151335	Period: From 07/01/2010 To 06/30/2011	Worksheet S-2 Part I Date/Time Prepared: 1/30/2012 5:43 pm	
			V 1.00	XIX 2.00	
Rural Providers					
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?		Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)		N		106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)		N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		N		108.00
		Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N
				1.00	2.00
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2.		N		115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.		N		116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.		Y		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.			1	118.00
119.00	What is the liability limit for the malpractice insurance policy? Enter in column 1 the monetary limit per lawsuit. Enter in column 2 the monetary limit per policy year.			1	119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 as amended by the Medicaid Extender Act (MMEA) §108? Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with <= 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121? Enter in column 2 "Y" for yes or "N" for no.		N		N
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.		N		121.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)		Y	15H046	140.00
		1.00	2.00	3.00	
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.					
141.00	Name: ST. VINCENT HEALTH	Contractor's Name: NGS		Contractor's Number: 00130	
142.00	Street: 10330 N. MERIDIAN ST.	PO Box:			
143.00	City: INDIANAPOLIS	State: IN		Zip Code: 46290	
				1.00	
144.00	Are provider based physicians' costs included in Worksheet A?		Y		144.00
145.00	If costs for renal services are claimed on worksheet A, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.		N		145.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151335		Period: From 07/01/2010 To 06/30/2011		Worksheet S-2 Part I Date/Time Prepared: 1/30/2012 5:43 pm		
		1.00			2.00			
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N					146.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N					147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N					148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N					149.00	
		Part A		Part B				
		1.00		2.00				
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)								
155.00	Hospital	N			N		155.00	
156.00	Subprovider - IPF	N			N		156.00	
157.00	Subprovider - IRF	N			N		157.00	
158.00	Subprovider - Other	N			N		158.00	
159.00	SNF	N			N		159.00	
160.00	HHA	N			N		160.00	
161.00	CMHC				N		161.00	
						1.00		
Multicampus								
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00	166.00
						1.00		
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act								
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.						N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)							0168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 151335	Period: From 07/01/2010 To 06/30/2011	Worksheet S-2 Part II Date/Time Prepared: 1/30/2012 5:43 pm
		Y/N 1.00	Date 2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	Y	07/01/2010	1.00
		Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "v" for voluntary or "i" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
		Y/N 1.00	Legal Oper. 2.00	
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N		9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
		Y/N 1.00		
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N		14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	Y		15.00
		Part A		
Description		Y/N	Date	
0		1.00	2.00	
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	11/08/2011	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 151335	Period: From 07/01/2010 To 06/30/2011	Worksheet S-2 Part II Date/Time Prepared: 1/30/2012 5:43 pm
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		Part A		
Description		Y/N	Date	
21.00	was the cost report prepared only using the provider's records? If yes, see instructions.	1.00	2.00	21.00
				1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)				
Capital Related Cost				
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N		27.00
Interest Expense				
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	N		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N		31.00
Purchased Services				
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N		33.00
Provider-Based Physicians				
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	N		35.00
		Y/N	Date	
		1.00	2.00	
Home Office Costs				
36.00	Were home office costs claimed on the cost report?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151335

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

Worksheet S-3
Part I
Date/Time Prepared:
1/30/2012 5:43 pm

Cost Center Description	Worksheet A	No. of Beds	Bed Days	CAH Hours	
	Line Number	2.00	Available	4.00	
	1.00		3.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	21	7,296	87,456.00	1.00
2.00 HMO					2.00
3.00 HMO IPF					3.00
4.00 HMO IRF					4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					5.00
6.00 Hospital Adults & Peds. Swing Bed NF					6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		21	7,296	87,456.00	7.00
8.00 INTENSIVE CARE UNIT	31.00	4	1,829	26,760.00	8.00
9.00 CORONARY CARE UNIT					9.00
10.00 BURN INTENSIVE CARE UNIT					10.00
11.00 SURGICAL INTENSIVE CARE UNIT					11.00
12.00 OTHER SPECIAL CARE (SPECIFY)					12.00
13.00 NURSERY	43.00				13.00
14.00 Total (see instructions)		25	9,125	114,216.00	14.00
15.00 CAH visits					15.00
16.00 SUBPROVIDER - IPF					16.00
17.00 SUBPROVIDER - IRF					17.00
18.00 SUBPROVIDER	42.00	0	0		18.00
19.00 SKILLED NURSING FACILITY	44.00	0	0		19.00
20.00 NURSING FACILITY					20.00
21.00 OTHER LONG TERM CARE					21.00
22.00 HOME HEALTH AGENCY	101.00				22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)					23.00
24.00 HOSPICE					24.00
25.00 CMHC - CMHC					25.00
26.00 RURAL HEALTH CLINIC					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER					26.25
27.00 Total (sum of lines 14-26)		25			27.00
28.00 Observation Bed Days					28.00
28.03 SUBPROVIDER	42.00				28.03
29.00 Ambulance Trips					29.00
30.00 Employee discount days (see instruction)					30.00
31.00 Employee discount days - IRF					31.00
32.00 Labor & delivery days (see instructions)					32.00
33.00 LTCH non-covered days					33.00

Cost Center Description	I/P Days / O/P Visits / Trips				Total All Patients	
	Title V	Title XVIII	Title XIX			
	5.00	6.00	7.00	8.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, observation Bed and Hospice days)	0	2,119	613	3,644	1.00	
2.00 HMO		0	0		2.00	
3.00 HMO IPF		0	0		3.00	
4.00 HMO IRF		0	0		4.00	
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0	0	5.00	
6.00 Hospital Adults & Peds. Swing Bed NF	0		0	0	6.00	
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	0	2,119	613	3,644	7.00	
8.00 INTENSIVE CARE UNIT	0	748	91	1,115	8.00	
9.00 CORONARY CARE UNIT					9.00	
10.00 BURN INTENSIVE CARE UNIT					10.00	
11.00 SURGICAL INTENSIVE CARE UNIT					11.00	
12.00 OTHER SPECIAL CARE (SPECIFY)					12.00	
13.00 NURSERY	0		83	628	13.00	
14.00 Total (see instructions)	0	2,867	787	5,387	14.00	
15.00 CAH visits	0	0	0	0	15.00	
16.00 SUBPROVIDER - IPF					16.00	
17.00 SUBPROVIDER - IRF					17.00	
18.00 SUBPROVIDER	0	0	0	0	18.00	
19.00 SKILLED NURSING FACILITY	0	0	0	0	19.00	
20.00 NURSING FACILITY					20.00	
21.00 OTHER LONG TERM CARE					21.00	
22.00 HOME HEALTH AGENCY	0	0	0	0	22.00	
23.00 AMBULATORY SURGICAL CENTER (D.P.)					23.00	
24.00 HOSPICE					24.00	
25.00 CMHC - CMHC					25.00	
26.00 RURAL HEALTH CLINIC					26.00	
26.25 FEDERALLY QUALIFIED HEALTH CENTER					26.25	
27.00 Total (sum of lines 14-26)					27.00	
28.00 Observation Bed Days	0		0	890	28.00	
28.03 SUBPROVIDER	0	0	0	0	28.03	
29.00 Ambulance Trips		423			29.00	
30.00 Employee discount days (see instruction)				26	30.00	
31.00 Employee discount days - IRF				0	31.00	
32.00 Labor & delivery days (see instructions)			0	0	32.00	
33.00 LTCH non-covered days		0			33.00	

Cost Center Description	Full Time Equivalents			Discharges		
	Total Interns & Residents	Employees On Payroll	Nonpaid workers	Title V	Title XVIII	
	9.00	10.00	11.00	12.00	13.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, observation Bed and Hospice days)				0	746	1.00
2.00 HMO					0	2.00
3.00 HMO IPF						3.00
4.00 HMO IRF						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	268.36	0.00	0	746	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER	0.00	0.00	0.00	0	0	18.00
19.00 SKILLED NURSING FACILITY	0.00	0.00	0.00			19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00	0.00	0.00			22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)	0.00	268.36	0.00			27.00
28.00 Observation Bed Days						28.00
28.03 SUBPROVIDER						28.03
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

Cost Center Description	Discharges			
	Title XIX	Total All Patients		
	14.00	15.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	275	1,257		1.00
2.00 HMO				2.00
3.00 HMO IPF				3.00
4.00 HMO IRF				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF				5.00
6.00 Hospital Adults & Peds. Swing Bed NF				6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)				7.00
8.00 INTENSIVE CARE UNIT				8.00
9.00 CORONARY CARE UNIT				9.00
10.00 BURN INTENSIVE CARE UNIT				10.00
11.00 SURGICAL INTENSIVE CARE UNIT				11.00
12.00 OTHER SPECIAL CARE (SPECIFY)				12.00
13.00 NURSERY				13.00
14.00 Total (see instructions)	275	1,257		14.00
15.00 CAH visits				15.00
16.00 SUBPROVIDER - IPF				16.00
17.00 SUBPROVIDER - IRF				17.00
18.00 SUBPROVIDER	0	0		18.00
19.00 SKILLED NURSING FACILITY				19.00
20.00 NURSING FACILITY				20.00
21.00 OTHER LONG TERM CARE				21.00
22.00 HOME HEALTH AGENCY				22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)				23.00
24.00 HOSPICE				24.00
25.00 CMHC - CMHC				25.00
26.00 RURAL HEALTH CLINIC				26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER				26.25
27.00 Total (sum of lines 14-26)				27.00
28.00 Observation Bed Days				28.00
28.03 SUBPROVIDER				28.03
29.00 Ambulance Trips				29.00
30.00 Employee discount days (see instruction)				30.00
31.00 Employee discount days - IRF				31.00
32.00 Labor & delivery days (see instructions)				32.00
33.00 LTCH non-covered days				33.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 151335	Period: From 07/01/2010 To 06/30/2011	Worksheet S-10 Date/Time Prepared: 1/30/2012 5:43 pm
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			1.00		
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (worksheet C, Part I line 200 column 3 divided by line 200 column 8)		0.505921	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		1,972,855	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?		N	3.00	
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?			4.00	
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		0	5.00	
6.00	Medicaid charges		10,383,448	6.00	
7.00	Medicaid cost (line 1 times line 6)		5,253,204	7.00	
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		3,280,349	8.00	
State Children's Health Insurance Program (SCHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone SCHIP		0	9.00	
10.00	Stand-alone SCHIP charges		0	10.00	
11.00	Stand-alone SCHIP cost (line 1 times line 10)		0	11.00	
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00	
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00	
Uncompensated care (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations		256,406	18.00	
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		3,280,349	19.00	
			Uninsured patients	Insured patients	Total (col. 1 + col. 2)
			1.00	2.00	3.00
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	2,257,663	0	2,257,663	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	1,142,199	0	1,142,199	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,142,199	0	1,142,199	23.00
			1.00		
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00	
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit		0	25.00	
26.00	Total bad debt expense for the entire hospital complex (see instructions)		2,208,098	26.00	
27.00	Medicare bad debts for the entire hospital complex (see instructions)		517,268	27.00	
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)		1,690,830	28.00	
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)		855,426	29.00	
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)		1,997,625	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		5,277,974	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151335

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

Worksheet A

Date/Time Prepared:
1/30/2012 5:43 pm

Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
	1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS						
1.00 CAP REL COSTS-BLDG & FIXT		833,771	833,771	-82,162	751,609	1.00
2.00 CAP REL COSTS-MVBLE EQUIP		648,593	648,593	43,923	692,516	2.00
4.00 EMPLOYEE BENEFITS	246,720	3,764,944	4,011,664	0	4,011,664	4.00
5.00 ADMINISTRATIVE & GENERAL	1,369,422	1,193,195	2,562,617	82,162	2,644,779	5.00
7.00 OPERATION OF PLANT	377,947	1,398,359	1,776,306	0	1,776,306	7.00
8.00 LAUNDRY & LINEN SERVICE	75,592	46,200	121,792	0	121,792	8.00
9.00 HOUSEKEEPING	289,126	81,290	370,416	0	370,416	9.00
10.00 DIETARY	303,176	321,801	624,977	-381,837	243,140	10.00
11.00 CAFETERIA	0	0	0	381,837	381,837	11.00
13.00 NURSING ADMINISTRATION	376,012	70,814	446,826	-273,298	173,528	13.00
14.00 CENTRAL SERVICES & SUPPLY	123,142	37,523	160,665	0	160,665	14.00
15.00 PHARMACY	403,737	1,088,311	1,492,048	0	1,492,048	15.00
16.00 MEDICAL RECORDS & LIBRARY	784,867	349,680	1,134,547	0	1,134,547	16.00
17.00 SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	2,238,862	309,849	2,548,711	-384,216	2,164,495	30.00
31.00 INTENSIVE CARE UNIT	1,067,935	122,108	1,190,043	0	1,190,043	31.00
42.00 SUBPROVIDER	0	0	0	0	0	42.00
43.00 NURSERY	0	0	0	194,096	194,096	43.00
44.00 SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	823,399	1,028,469	1,851,868	0	1,851,868	50.00
51.00 RECOVERY ROOM	0	0	0	0	0	51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	463,418	463,418	52.00
53.00 ANESTHESIOLOGY	31,482	5,304	36,786	0	36,786	53.00
54.00 RADIOLOGY-DIAGNOSTIC	757,297	650,452	1,407,749	-43,923	1,363,826	54.00
57.00 CT SCAN	0	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	385,090	1,112,022	1,497,112	0	1,497,112	59.00
60.00 LABORATORY	787,294	1,457,034	2,244,328	0	2,244,328	60.00
64.00 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 RESPIRATORY THERAPY	481,425	62,187	543,612	0	543,612	65.00
66.00 PHYSICAL THERAPY	279,001	31,199	310,200	0	310,200	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	152,397	92,196	244,593	0	244,593	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00 RENAL DIALYSIS	0	0	0	0	0	74.00
76.97 CARDIAC REHABILITATION	78,601	4,649	83,250	0	83,250	76.97
OUTPATIENT SERVICE COST CENTERS						
91.00 EMERGENCY	801,014	733,558	1,534,572	0	1,534,572	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 AMBULANCE SERVICES	215,203	92,613	307,816	0	307,816	95.00
101.00 HOME HEALTH AGENCY	2,946	75	3,021	0	3,021	101.00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1-117)	12,451,687	15,536,196	27,987,883	0	27,987,883	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00 NONPAID WORKERS	0	0	0	0	0	193.00
194.00 MARKETING	26,257	4,746	31,003	0	31,003	194.00
194.01 FOUNDATION	41,034	1,434	42,468	0	42,468	194.01
194.02 COMMUNITY OUTREACH	156,962	29,848	186,810	0	186,810	194.02
194.03 WIC	121,054	52,384	173,438	0	173,438	194.03
194.04 GRANTS	78,469	22,554	101,023	0	101,023	194.04
194.05 VACANT SPACE	0	0	0	0	0	194.05
200.00 TOTAL (SUM OF LINES 118-199)	12,875,463	15,647,162	28,522,625	0	28,522,625	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151335

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

Worksheet A

Date/Time Prepared:
1/30/2012 5:43 pm

Cost Center Description		Adjustments (See A-8) 6.00	Net Expenses For Allocation 7.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	148,157	899,766	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	692,516	2.00
4.00	EMPLOYEE BENEFITS	-39,428	3,972,236	4.00
5.00	ADMINISTRATIVE & GENERAL	2,264,998	4,909,777	5.00
7.00	OPERATION OF PLANT	-67,145	1,709,161	7.00
8.00	LAUNDRY & LINEN SERVICE	0	121,792	8.00
9.00	HOUSEKEEPING	0	370,416	9.00
10.00	DIETARY	-2,346	240,794	10.00
11.00	CAFETERIA	-110,230	271,607	11.00
13.00	NURSING ADMINISTRATION	-630	172,898	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	160,665	14.00
15.00	PHARMACY	-13,220	1,478,828	15.00
16.00	MEDICAL RECORDS & LIBRARY	-21,367	1,113,180	16.00
17.00	SOCIAL SERVICE	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	-1,930	2,162,565	30.00
31.00	INTENSIVE CARE UNIT	0	1,190,043	31.00
42.00	SUBPROVIDER	0	0	42.00
43.00	NURSERY	0	194,096	43.00
44.00	SKILLED NURSING FACILITY	0	0	44.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0	1,851,868	50.00
51.00	RECOVERY ROOM	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	463,418	52.00
53.00	ANESTHESIOLOGY	0	36,786	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	1,363,826	54.00
57.00	CT SCAN	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	1,497,112	59.00
60.00	LABORATORY	-1,143	2,243,185	60.00
64.00	INTRAVENOUS THERAPY	0	0	64.00
65.00	RESPIRATORY THERAPY	0	543,612	65.00
66.00	PHYSICAL THERAPY	-11,814	298,386	66.00
67.00	OCCUPATIONAL THERAPY	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	68.00
69.00	ELECTROCARDIOLOGY	-59,626	184,967	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	RENAL DIALYSIS	0	0	74.00
76.97	CARDIAC REHABILITATION	0	83,250	76.97
OUTPATIENT SERVICE COST CENTERS				
91.00	EMERGENCY	0	1,534,572	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	AMBULANCE SERVICES	0	307,816	95.00
101.00	HOME HEALTH AGENCY	0	3,021	101.00
SPECIAL PURPOSE COST CENTERS				
118.00	SUBTOTALS (SUM OF LINES 1-117)	2,084,276	30,072,159	118.00
NONREIMBURSABLE COST CENTERS				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
193.00	NONPAID WORKERS	0	0	193.00
194.00	MARKETING	387,537	418,540	194.00
194.01	FOUNDATION	0	42,468	194.01
194.02	COMMUNITY OUTREACH	0	186,810	194.02
194.03	WIC	0	173,438	194.03
194.04	GRANTS	0	101,023	194.04
194.05	VACANT SPACE	0	0	194.05
200.00	TOTAL (SUM OF LINES 118-199)	2,471,813	30,994,438	200.00

		Increases				
Cost Center		Line #	Salary	Other		
2.00		3.00	4.00	5.00		
A - CAFETERIA						
1.00	CAFETERIA	11.00	185,229	196,608	1.00	
	TOTALS		185,229	196,608		
B - INTEREST EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	82,162	1.00	
	TOTALS		0	82,162		
C - NURSERY AND OB						
1.00	NURSERY	43.00	174,780	19,316	1.00	
2.00	DELIVERY ROOM & LABOR ROOM	52.00	417,299	46,119	2.00	
	TOTALS		592,079	65,435		
D - MED SURG ASSOCIATES						
1.00	ADULTS & PEDIATRICS	30.00	273,298	0	1.00	
	TOTALS		273,298	0		
E - CAPITAL RECLASS						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	43,923	1.00	
	TOTALS		0	43,923		
500.00	Grand Total: Increases		1,050,606	388,128	500.00	

		Decreases				wkst. A-7 Ref.	
Cost Center	Line #	Salary	Other				
	6.00	7.00	8.00	9.00	10.00		
A - CAFETERIA							
1.00	DIETARY	10.00	185,229	196,608	0		1.00
	TOTALS		185,229	196,608			
B - INTEREST EXPENSE							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	82,162	9		1.00
	TOTALS		0	82,162			
C - NURSERY AND OB							
1.00	ADULTS & PEDIATRICS	30.00	592,079	65,435	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		592,079	65,435			
D - MED SURG ASSOCIATES							
1.00	NURSING ADMINISTRATION	13.00	273,298	0	0		1.00
	TOTALS		273,298	0			
E - CAPITAL RECLASS							
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	43,923	9		1.00
	TOTALS		0	43,923			
500.00	Grand Total: Decreases		1,050,606	388,128			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151335

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
1/30/2012 5:43 pm

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	100,000	0	100,000	0 1.00
2.00	Land Improvements	0	60,000	0	60,000	0 2.00
3.00	Buildings and Fixtures	0	5,495,328	0	5,495,328	0 3.00
4.00	Building Improvements	0	0	0	0	0 4.00
5.00	Fixed Equipment	0	3,599,153	0	3,599,153	0 5.00
6.00	Movable Equipment	0	0	0	0	0 6.00
7.00	HIT designated Assets	0	0	0	0	0 7.00
8.00	Subtotal (sum of lines 1-7)	0	9,254,481	0	9,254,481	0 8.00
9.00	Reconciling Items	0	0	0	0	0 9.00
10.00	Total (line 8 minus line 9)	0	9,254,481	0	9,254,481	0 10.00
SUMMARY OF CAPITAL						
Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
	9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	493,175	0	304,234	25,084	0 1.00
2.00	CAP REL COSTS-MVBLE EQUIP	634,339	0	0	14,254	0 2.00
3.00	Total (sum of lines 1-2)	1,127,514	0	304,234	39,338	0 3.00
COMPUTATION OF RATIOS						
Cost Center Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL Ratio (see instructions)	Insurance	
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	5,495,328	0	5,495,328	0.593802	0 1.00
2.00	CAP REL COSTS-MVBLE EQUIP	3,759,153	0	3,759,153	0.406198	0 2.00
3.00	Total (sum of lines 1-2)	9,254,481	0	9,254,481	1.000000	0 3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151335

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
1/30/2012 5:43 pm

		Ending Balance	Fully Depreciated Assets			
		6.00	7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	100,000	0		1.00	
2.00	Land Improvements	60,000	0		2.00	
3.00	Buildings and Fixtures	5,495,328	0		3.00	
4.00	Building Improvements	0	0		4.00	
5.00	Fixed Equipment	3,599,153	0		5.00	
6.00	Movable Equipment	0	0		6.00	
7.00	HIT designated Assets	0	0		7.00	
8.00	Subtotal (sum of lines 1-7)	9,254,481	0		8.00	
9.00	Reconciling Items	0	0		9.00	
10.00	Total (line 8 minus line 9)	9,254,481	0		10.00	
SUMMARY OF CAPITAL						
Cost Center Description		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)			
		14.00	15.00			
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	11,278	833,771		1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	0	648,593		2.00	
3.00	Total (sum of lines 1-2)	11,278	1,482,364		3.00	
ALLOCATION OF OTHER CAPITAL						
Cost Center Description		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL Depreciation	Lease
		6.00	7.00	8.00	9.00	10.00
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	559,170	0
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	678,262	0
3.00	Total (sum of lines 1-2)	0	0	0	1,237,432	0

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151335

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
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Cost Center Description	SUMMARY OF CAPITAL					Total (2) (sum of cols. 9 through 14)	
	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
	11.00	12.00	13.00	14.00	15.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	304,234	25,084	0	11,278	899,766	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	14,254	0	0	692,516	2.00
3.00	Total (sum of lines 1-2)	304,234	39,338	0	11,278	1,592,282	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 151335

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

Worksheet A-8

Date/Time Prepared:
1/30/2012 5:43 pm

		Expense Classification on worksheet A To/From Which the Amount is to be Adjusted			
		Basis/Code (2)	Amount	Cost Center	Line #
		1.00	2.00	3.00	4.00
1.00	Investment income - buildings and fixtures (chapter 2)	B	-16,764	CAP REL COSTS-BLDG & FIXT	1.00 1.00
2.00	Investment income - movable equipment (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00 2.00
3.00	Investment income - other (chapter 2)	B	-6,202	ADMINISTRATIVE & GENERAL	5.00 3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00 4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00 5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00 6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-2,965	OPERATION OF PLANT	7.00 7.00
8.00	Television and radio service (chapter 21)		0		0.00 8.00
9.00	Parking lot (chapter 21)		0		0.00 9.00
10.00	Provider-based physician adjustment	A-8-2	-59,626		10.00 10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00 11.00
12.00	Related organization transactions (chapter 10)	A-8-1	2,807,176		12.00 12.00
13.00	Laundry and linen service		0		0.00 13.00
14.00	Cafeteria-employees and guests	B	-110,230	CAFETERIA	11.00 14.00
15.00	Rental of quarters to employee and others		0		0.00 15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00 16.00
17.00	Sale of drugs to other than patients		0		0.00 17.00
18.00	Sale of medical records and abstracts	B	-21,367	MEDICAL RECORDS & LIBRARY	16.00 18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00 19.00
20.00	Vending machines		0		0.00 20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00 21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00 22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00 23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00 24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00 25.00
26.00	Depreciation - buildings and fixtures		0	CAP REL COSTS-BLDG & FIXT	1.00 26.00
27.00	Depreciation - movable equipment		0	CAP REL COSTS-MVBLE EQUIP	2.00 27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00 28.00
29.00	Physicians' assistant		0		0.00 29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00 30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00 31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00 32.00
33.00	LOBBYING EXPENSE	A	-2,147	ADMINISTRATIVE & GENERAL	5.00 33.00
33.01	LOSS ON FIXED ASSETS	A	-11,278	CAP REL COSTS-BLDG & FIXT	1.00 33.01
33.02	DONATIONS	A	-225	ADMINISTRATIVE & GENERAL	5.00 33.02
33.03	ENTERTAINMENT	A	-68	LABORATORY	60.00 33.03
33.04	RENTAL INCOME	B	-63,885	OPERATION OF PLANT	7.00 33.04
33.05	INTEREST INCOME	B	-295	OPERATION OF PLANT	7.00 33.05
33.06	PHYSICIAN RECRUITMENT	A	-496	ADMINISTRATIVE & GENERAL	5.00 33.06
33.07	MISC OB REVENUE	B	-1,930	ADULTS & PEDIATRICS	30.00 33.07
33.08	DNA TESTING REVENUE	B	-1,075	LABORATORY	60.00 33.08
33.09	MISC. PHARMACY REVENUE	B	-13,220	PHARMACY	15.00 33.09
33.10	PT SERVICES CONTRACT	B	-11,814	PHYSICAL THERAPY	66.00 33.10
33.11	MISC INCOME	B	-8,780	ADMINISTRATIVE & GENERAL	5.00 33.11
33.12	ACL/CPR CLASS REVENUE	B	-630	NURSING ADMINISTRATION	13.00 33.12
33.13	MISC REV	B	-20	ADMINISTRATIVE & GENERAL	5.00 33.13
33.14	MISC REV	B	-2,346	DIETARY	10.00 33.14
33.15			0		0.00 33.15
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200.)		2,471,813		50.00 50.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 151335

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

Worksheet A-8

Date/Time Prepared:
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		Wkst. A-7 Ref.	
		5.00	
1.00	Investment income - buildings and fixtures (chapter 2)	9	1.00
2.00	Investment income - movable equipment (chapter 2)	0	2.00
3.00	Investment income - other (chapter 2)	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	0	7.00
8.00	Television and radio service (chapter 21)	0	8.00
9.00	Parking lot (chapter 21)	0	9.00
10.00	Provider-based physician adjustment	0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	0	11.00
12.00	Related organization transactions (chapter 10)	0	12.00
13.00	Laundry and linen service	0	13.00
14.00	Cafeteria-employees and guests	0	14.00
15.00	Rental of quarters to employee and others	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	0	16.00
17.00	Sale of drugs to other than patients	0	17.00
18.00	Sale of medical records and abstracts	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)	0	19.00
20.00	Vending machines	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		25.00
26.00	Depreciation - buildings and fixtures	0	26.00
27.00	Depreciation - movable equipment	0	27.00
28.00	Non-physician Anesthetist		28.00
29.00	Physicians' assistant	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)		30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	0	32.00
33.00	LOBBYING EXPENSE	0	33.00
33.01	LOSS ON FIXED ASSETS	9	33.01
33.02	DONATIONS	0	33.02
33.03	ENTERTAINMENT	0	33.03
33.04	RENTAL INCOME	0	33.04
33.05	INTEREST INCOME	0	33.05
33.06	PHYSICIAN RECRUITMENT	0	33.06
33.07	MISC OB REVENUE	0	33.07
33.08	DNA TESTING REVENUE	0	33.08
33.09	MISC. PHARMACY REVENUE	0	33.09
33.10	PT SERVICES CONTRACT	0	33.10
33.11	MISC INCOME	0	33.11
33.12	ACL/CPR CLASS REVENUE	0	33.12
33.13	MISC REV	0	33.13
33.14	MISC REV	0	33.14
33.15		0	33.15
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200.)		50.00

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

Provider CCN: 151335

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

Worksheet A-8-1

Date/Time Prepared:
1/30/2012 5:43 pm

	Line No.	Cost Center	Expense Items	
	1.00	2.00	3.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	2.00
3.00	194.00	MARKETING	HOME OFFICE	3.00
4.00	4.00	EMPLOYEE BENEFITS	SELF INSURANCE	4.00
4.01	1.00	CAP REL COSTS-BLDG & FIXT	ASCENSION INTEREST	4.01
4.02	5.00	ADMINISTRATIVE & GENERAL	ASCENSION INTEREST	4.02
4.03	5.00	ADMINISTRATIVE & GENERAL	ASCENSION MAINTENANCE	4.03
4.04	5.00	ADMINISTRATIVE & GENERAL	INCENTIVE PAYROLL	4.04
4.05	4.00	EMPLOYEE BENEFITS	PENSION	4.05
4.06	0.00			4.06
4.07	0.00			4.07
4.08	0.00			4.08
4.09	0.00			4.09
4.10	0.00			4.10
4.11	0.00			4.11
4.12	0.00			4.12
4.13	0.00			4.13
4.14	0.00			4.14
4.15	0.00			4.15
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to worksheet A-8, column 2, line 12.			5.00

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

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

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

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

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

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

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

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

Provider CCN: 151335

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

Worksheet A-8-1

Date/Time Prepared: 1/30/2012 5:43 pm

	Amount of Allowable Cost	Amount Included in wks. A, column 5	Net Adjustments (col. 4 minus col. 5)*	wkst. A-7 Ref.	
	4.00	5.00	6.00	7.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	323,746	0	323,746	9	1.00
2.00	2,362,889	0	2,362,889	0	2.00
3.00	387,537	0	387,537	0	3.00
4.00	863,306	902,734	-39,428	0	4.00
4.01	74,524	222,071	-147,547	9	4.01
4.02	27,572	82,162	-54,590	0	4.02
4.03	372,702	400,582	-27,880	0	4.03
4.04	84,653	82,204	2,449	0	4.04
4.05	774,000	774,000	0	0	4.05
4.06	0	0	0	0	4.06
4.07	0	0	0	0	4.07
4.08	0	0	0	0	4.08
4.09	0	0	0	0	4.09
4.10	0	0	0	0	4.10
4.11	0	0	0	0	4.11
4.12	0	0	0	0	4.12
4.13	0	0	0	0	4.13
4.14	0	0	0	0	4.14
4.15	0	0	0	0	4.15
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to worksheet A-8, column 2, line 12.	5,270,929	2,463,753	2,807,176	5.00

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

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

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

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

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

6.00	ST. VINCENT HEA	100.00	ADMINISTRATION	6.00
7.00	ASCENSION	100.00	ADMINISTRATION	7.00
8.00	ST. VINCENT HOS	100.00	HOSPITAL	8.00
9.00		0.00		9.00
10.00		0.00		10.00
100.00	G. Other (financial or non-financial) specify:			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151335

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

Worksheet A-8-2

Date/Time Prepared:
1/30/2012 5:43 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
	1.00	2.00	3.00	4.00	
1.00	69.00	ELECTROCARDIOLOGY	59,626	59,626	1.00
2.00	0.00		0	0	2.00
3.00	0.00		0	0	3.00
4.00	0.00		0	0	4.00
5.00	0.00		0	0	5.00
6.00	0.00		0	0	6.00
7.00	0.00		0	0	7.00
8.00	0.00		0	0	8.00
9.00	0.00		0	0	9.00
10.00	0.00		0	0	10.00
200.00		TOTAL (lines 1.00 through 199.00)	59,626	59,626	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151335

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

Worksheet A-8-2

Date/Time Prepared:
1/30/2012 5:43 pm

	Provider Component	RCE Amount	Physician/Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	5.00	6.00	7.00	8.00	9.00	
1.00	0	0	0	0	0	1.00
2.00	0	0	0	0	0	2.00
3.00	0	0	0	0	0	3.00
4.00	0	0	0	0	0	4.00
5.00	0	0	0	0	0	5.00
6.00	0	0	0	0	0	6.00
7.00	0	0	0	0	0	7.00
8.00	0	0	0	0	0	8.00
9.00	0	0	0	0	0	9.00
10.00	0	0	0	0	0	10.00
200.00	0	0	0	0	0	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151335

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

Worksheet A-8-2

Date/Time Prepared:
1/30/2012 5:43 pm

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151335

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

Worksheet A-8-2

Date/Time Prepared:
1/30/2012 5:43 pm

	RCE Disallowance	Adjustment	
	17.00	18.00	
1.00	0	59,626	1.00
2.00	0	0	2.00
3.00	0	0	3.00
4.00	0	0	4.00
5.00	0	0	5.00
6.00	0	0	6.00
7.00	0	0	7.00
8.00	0	0	8.00
9.00	0	0	9.00
10.00	0	0	10.00
200.00	0	59,626	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151335

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

Worksheet B
Part I
Date/Time Prepared:
1/30/2012 5:43 pm

Cost Center Description	Net Expenses for Cost Allocation (from wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	899,766	899,766			1.00
2.00	CAP REL COSTS-MVBLE EQUIP	692,516		692,516		2.00
4.00	EMPLOYEE BENEFITS	3,972,236	29,793	22,930	4,024,959	4.00
5.00	ADMINISTRATIVE & GENERAL	4,909,777	134,868	103,803	436,454	5,584,902
7.00	OPERATION OF PLANT	1,709,161	93,360	71,856	120,457	1,994,834
8.00	LAUNDRY & LINEN SERVICE	121,792	15,478	11,913	24,092	173,275
9.00	HOUSEKEEPING	370,416	15,167	11,674	92,149	489,406
10.00	DIETARY	240,794	12,971	9,983	37,591	301,339
11.00	CAFETERIA	271,607	33,540	25,814	59,035	389,996
13.00	NURSING ADMINISTRATION	172,898	7,584	5,837	32,736	219,055
14.00	CENTRAL SERVICES & SUPPLY	160,665	19,117	14,714	39,247	233,743
15.00	PHARMACY	1,478,828	11,906	9,163	128,677	1,628,574
16.00	MEDICAL RECORDS & LIBRARY	1,113,180	36,198	27,860	250,148	1,427,386
17.00	SOCIAL SERVICE	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	2,162,565	58,228	44,816	611,958	2,877,567
31.00	INTENSIVE CARE UNIT	1,190,043	19,848	15,276	340,366	1,565,533
42.00	SUBPROVIDER	0	0	0	0	0
43.00	NURSERY	194,096	3,540	2,724	55,705	256,065
44.00	SKILLED NURSING FACILITY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	1,851,868	52,986	40,782	262,429	2,208,065
51.00	RECOVERY ROOM	0	0	0	0	0
52.00	DELIVERY ROOM & LABOR ROOM	463,418	48,749	37,520	132,999	682,686
53.00	ANESTHESIOLOGY	36,786	1,777	1,368	10,034	49,965
54.00	RADIOLOGY-DIAGNOSTIC	1,363,826	43,442	33,436	241,361	1,682,065
57.00	CT SCAN	0	0	0	0	0
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00	CARDIAC CATHETERIZATION	1,497,112	18,481	14,224	122,734	1,652,551
60.00	LABORATORY	2,243,185	36,127	27,806	250,922	2,558,040
64.00	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	RESPIRATORY THERAPY	543,612	10,685	8,224	153,437	715,958
66.00	PHYSICAL THERAPY	298,386	21,181	16,303	88,922	424,792
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	SPEECH PATHOLOGY	0	0	0	0	0
69.00	ELECTROCARDIOLOGY	184,967	13,381	10,299	48,571	257,218
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
74.00	RENAL DIALYSIS	0	0	0	0	0
76.97	CARDIAC REHABILITATION	83,250	6,330	4,872	25,051	119,503
OUTPATIENT SERVICE COST CENTERS						
91.00	EMERGENCY	1,534,572	27,837	21,425	255,294	1,839,128
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	307,816	0	0	68,588	376,404
101.00	HOME HEALTH AGENCY	3,021	0	0	939	3,960
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	30,072,159	772,574	594,622	3,889,896	29,712,010
NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,946	2,267	0	5,213
192.00	PHYSICIANS' PRIVATE OFFICES	0	87,667	67,474	0	155,141
193.00	NONPAID WORKERS	0	0	0	0	0
194.00	MARKETING	418,540	1,546	1,190	8,368	429,644
194.01	FOUNDATION	42,468	952	733	13,078	57,231
194.02	COMMUNITY OUTREACH	186,810	8,309	6,395	50,026	251,540
194.03	WIC	173,438	7,895	6,076	38,582	225,991
194.04	GRANTS	101,023	4,567	3,515	25,009	134,114
194.05	VACANT SPACE	0	13,310	10,244	0	23,554
200.00	Cross Foot Adjustments	0	0	0	0	0
201.00	Negative Cost Centers	0	0	0	0	0
202.00	TOTAL (sum lines 118-201)	30,994,438	899,766	692,516	4,024,959	30,994,438

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151335

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

Worksheet B
Part I
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Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL	5,584,902					5.00
7.00	OPERATION OF PLANT	438,457	2,433,291				7.00
8.00	LAUNDRY & LINEN SERVICE	38,085	61,981	273,341			8.00
9.00	HOUSEKEEPING	107,569	60,735	2,552	660,262		9.00
10.00	DIETARY	66,233	51,940	1,411	14,326	435,249	10.00
11.00	CAFETERIA	85,720	134,304	0	37,045	0	11.00
13.00	NURSING ADMINISTRATION	48,147	30,368	0	8,376	0	13.00
14.00	CENTRAL SERVICES & SUPPLY	51,376	76,551	0	21,115	0	14.00
15.00	PHARMACY	357,954	47,675	0	13,150	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	313,734	144,949	0	39,981	0	16.00
17.00	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	632,466	233,164	102,550	64,313	333,827	30.00
31.00	INTENSIVE CARE UNIT	344,098	79,477	29,533	21,922	101,422	31.00
42.00	SUBPROVIDER	0	0	0	0	0	42.00
43.00	NURSERY	56,282	14,174	4,886	3,910	0	43.00
44.00	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	485,324	212,176	38,816	58,524	0	50.00
51.00	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	150,052	195,209	9,989	53,844	0	52.00
53.00	ANESTHESIOLOGY	10,982	7,115	0	1,963	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	369,711	173,957	15,201	47,982	0	54.00
57.00	CT SCAN	0	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	363,224	74,003	5,646	20,412	0	59.00
60.00	LABORATORY	562,247	144,666	0	39,903	0	60.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	157,365	42,786	0	11,802	0	65.00
66.00	PHYSICAL THERAPY	93,368	84,818	6,026	23,395	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	56,535	53,582	3,040	14,779	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	CARDIAC REHABILITATION	26,266	25,347	0	6,991	0	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	EMERGENCY	404,233	111,467	51,139	30,746	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	AMBULANCE SERVICES	82,732	0	1,249	0	0	95.00
101.00	HOME HEALTH AGENCY	870	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	5,303,030	2,060,444	272,038	534,479	435,249	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,146	11,796	0	3,254	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	34,099	351,048	0	96,827	0	192.00
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	MARKETING	94,434	6,191	0	1,708	0	194.00
194.01	FOUNDATION	12,579	3,812	0	1,052	0	194.01
194.02	COMMUNITY OUTREACH	55,287	0	0	9,178	0	194.02
194.03	WIC	49,672	0	1,303	8,720	0	194.03
194.04	GRANTS	29,478	0	0	5,044	0	194.04
194.05	VACANT SPACE	5,177	0	0	0	0	194.05
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	5,584,902	2,433,291	273,341	660,262	435,249	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151335

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

Worksheet B
Part I
Date/Time Prepared:
1/30/2012 5:43 pm

Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
	11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS						
1.00						1.00
2.00						2.00
4.00						4.00
5.00						5.00
7.00						7.00
8.00						8.00
9.00						9.00
10.00						10.00
11.00	647,065					11.00
13.00	5,023	310,969				13.00
14.00	10,152	0	392,937			14.00
15.00	18,117	0	17,281	2,082,751		15.00
16.00	72,585	0	0	0	1,998,635	16.00
17.00	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	131,516	135,160	39,039	0	79,879	30.00
31.00	44,562	45,796	12,932	0	51,539	31.00
42.00	0	0	0	0	0	42.00
43.00	9,056	9,306	0	0	13,013	43.00
44.00	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00	47,648	48,967	188,678	0	247,654	50.00
51.00	0	0	0	0	0	51.00
52.00	21,622	22,220	0	0	30,421	52.00
53.00	309	0	0	0	5,652	53.00
54.00	48,079	0	13,893	0	450,323	54.00
57.00	0	0	0	0	0	57.00
58.00	0	0	0	0	0	58.00
59.00	14,395	0	88,200	0	172,924	59.00
60.00	65,972	0	13,529	0	352,128	60.00
64.00	0	0	0	0	0	64.00
65.00	22,876	0	998	0	87,236	65.00
66.00	15,563	0	2,067	0	47,132	66.00
67.00	0	0	0	0	0	67.00
68.00	0	0	0	0	0	68.00
69.00	11,355	0	1,403	0	87,789	69.00
70.00	0	0	0	0	0	70.00
71.00	0	0	0	0	0	71.00
72.00	0	0	0	0	0	72.00
73.00	0	0	0	2,082,751	180,508	73.00
74.00	0	0	0	0	0	74.00
76.97	5,677	0	188	0	6,771	76.97
OUTPATIENT SERVICE COST CENTERS						
91.00	48,187	49,520	13,002	0	165,432	91.00
92.00						92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	19,929	0	971	0	20,234	95.00
101.00	141	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
118.00	612,764	310,969	392,181	2,082,751	1,998,635	118.00
NONREIMBURSABLE COST CENTERS						
190.00	0	0	0	0	0	190.00
192.00	0	0	0	0	0	192.00
193.00	0	0	0	0	0	193.00
194.00	2,143	0	0	0	0	194.00
194.01	3,202	0	0	0	0	194.01
194.02	11,492	0	377	0	0	194.02
194.03	11,116	0	7	0	0	194.03
194.04	6,348	0	372	0	0	194.04
194.05	0	0	0	0	0	194.05
200.00						200.00
201.00	0	0	0	0	0	201.00
202.00	647,065	310,969	392,937	2,082,751	1,998,635	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151335

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

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00					1.00
2.00					2.00
4.00					4.00
5.00					5.00
7.00					7.00
8.00					8.00
9.00					9.00
10.00					10.00
11.00					11.00
13.00					13.00
14.00					14.00
15.00					15.00
16.00					16.00
17.00	0				17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	0	4,629,481	0	4,629,481	30.00
31.00	0	2,296,814	0	2,296,814	31.00
42.00	0	0	0	0	42.00
43.00	0	366,692	0	366,692	43.00
44.00	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS					
50.00	0	3,535,852	0	3,535,852	50.00
51.00	0	0	0	0	51.00
52.00	0	1,166,043	0	1,166,043	52.00
53.00	0	75,986	0	75,986	53.00
54.00	0	2,801,211	0	2,801,211	54.00
57.00	0	0	0	0	57.00
58.00	0	0	0	0	58.00
59.00	0	2,391,355	0	2,391,355	59.00
60.00	0	3,736,485	0	3,736,485	60.00
64.00	0	0	0	0	64.00
65.00	0	1,039,021	0	1,039,021	65.00
66.00	0	697,161	0	697,161	66.00
67.00	0	0	0	0	67.00
68.00	0	0	0	0	68.00
69.00	0	485,701	0	485,701	69.00
70.00	0	0	0	0	70.00
71.00	0	0	0	0	71.00
72.00	0	0	0	0	72.00
73.00	0	2,263,259	0	2,263,259	73.00
74.00	0	0	0	0	74.00
76.97	0	190,743	0	190,743	76.97
OUTPATIENT SERVICE COST CENTERS					
91.00	0	2,712,854	0	2,712,854	91.00
92.00	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	0	501,519	0	501,519	95.00
101.00	0	4,971	0	4,971	101.00
SPECIAL PURPOSE COST CENTERS					
118.00	0	28,895,148	0	28,895,148	118.00
NONREIMBURSABLE COST CENTERS					
190.00	0	21,409	0	21,409	190.00
192.00	0	637,115	0	637,115	192.00
193.00	0	0	0	0	193.00
194.00	0	534,120	0	534,120	194.00
194.01	0	77,876	0	77,876	194.01
194.02	0	327,874	0	327,874	194.02
194.03	0	296,809	0	296,809	194.03
194.04	0	175,356	0	175,356	194.04
194.05	0	28,731	0	28,731	194.05
200.00	0	0	0	0	200.00
201.00	0	0	0	0	201.00
202.00	0	30,994,438	0	30,994,438	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151335

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

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	EMPLOYEE BENEFITS	0	29,793	22,930	52,723	4.00
5.00	ADMINISTRATIVE & GENERAL	142,184	134,868	103,803	380,855	5.00
7.00	OPERATION OF PLANT	9,542	93,360	71,856	174,758	7.00
8.00	LAUNDRY & LINEN SERVICE	0	15,478	11,913	27,391	8.00
9.00	HOUSEKEEPING	0	15,167	11,674	26,841	9.00
10.00	DIETARY	0	12,971	9,983	22,954	10.00
11.00	CAFETERIA	0	33,540	25,814	59,354	11.00
13.00	NURSING ADMINISTRATION	0	7,584	5,837	13,421	13.00
14.00	CENTRAL SERVICES & SUPPLY	266	19,117	14,714	34,097	14.00
15.00	PHARMACY	0	11,906	9,163	21,069	15.00
16.00	MEDICAL RECORDS & LIBRARY	14,778	36,198	27,860	78,836	16.00
17.00	SOCIAL SERVICE	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	16,675	58,228	44,816	119,719	30.00
31.00	INTENSIVE CARE UNIT	3,250	19,848	15,276	38,374	31.00
42.00	SUBPROVIDER	0	0	0	0	42.00
43.00	NURSERY	0	3,540	2,724	6,264	43.00
44.00	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	108,580	52,986	40,782	202,348	50.00
51.00	RECOVERY ROOM	0	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	48,749	37,520	86,269	52.00
53.00	ANESTHESIOLOGY	0	1,777	1,368	3,145	53.00
54.00	RADIOLOGY-DIAGNOSTIC	263,920	43,442	33,436	340,798	54.00
57.00	CT SCAN	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	1,470	18,481	14,224	34,175	59.00
60.00	LABORATORY	41,855	36,127	27,806	105,788	60.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	759	10,685	8,224	19,668	65.00
66.00	PHYSICAL THERAPY	36	21,181	16,303	37,520	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	13,381	10,299	23,680	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	RENAL DIALYSIS	0	0	0	0	74.00
76.97	CARDIAC REHABILITATION	0	6,330	4,872	11,202	76.97
OUTPATIENT SERVICE COST CENTERS						
91.00	EMERGENCY	1,600	27,837	21,425	50,862	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	51,934	0	0	51,934	95.00
101.00	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	656,849	772,574	594,622	2,024,045	118.00
NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,946	2,267	5,213	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	87,667	67,474	155,141	192.00
193.00	NONPAID WORKERS	0	0	0	0	193.00
194.00	MARKETING	0	1,546	1,190	2,736	194.00
194.01	FOUNDATION	0	952	733	1,685	194.01
194.02	COMMUNITY OUTREACH	0	8,309	6,395	14,704	194.02
194.03	WIC	39,765	7,895	6,076	53,736	194.03
194.04	GRANTS	0	4,567	3,515	8,082	194.04
194.05	VACANT SPACE	0	13,310	10,244	23,554	194.05
200.00	Cross Foot Adjustments	0	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	696,614	899,766	692,516	2,288,896	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151335

Period:
From 07/01/2010
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Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL	386,572					5.00
7.00	OPERATION OF PLANT	30,349	206,685				7.00
8.00	LAUNDRY & LINEN SERVICE	2,636	5,265	35,608			8.00
9.00	HOUSEKEEPING	7,446	5,159	332	40,985		9.00
10.00	DIETARY	4,585	4,412	184	889	33,516	10.00
11.00	CAFETERIA	5,933	11,408	0	2,300	0	11.00
13.00	NURSING ADMINISTRATION	3,333	2,579	0	520	0	13.00
14.00	CENTRAL SERVICES & SUPPLY	3,556	6,502	0	1,311	0	14.00
15.00	PHARMACY	24,777	4,050	0	816	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	21,716	12,312	0	2,482	0	16.00
17.00	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	43,772	19,805	13,360	3,992	25,706	30.00
31.00	INTENSIVE CARE UNIT	23,818	6,751	3,847	1,361	7,810	31.00
42.00	SUBPROVIDER	0	0	0	0	0	42.00
43.00	NURSERY	3,896	1,204	636	243	0	43.00
44.00	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	33,594	18,022	5,057	3,633	0	50.00
51.00	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	10,386	16,581	1,301	3,342	0	52.00
53.00	ANESTHESIOLOGY	760	604	0	122	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	25,591	14,776	1,980	2,978	0	54.00
57.00	CT SCAN	0	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	25,142	6,286	735	1,267	0	59.00
60.00	LABORATORY	38,918	12,288	0	2,477	0	60.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	10,893	3,634	0	733	0	65.00
66.00	PHYSICAL THERAPY	6,463	7,204	785	1,452	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	3,913	4,551	396	917	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	CARDIAC REHABILITATION	1,818	2,153	0	434	0	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	EMERGENCY	27,980	9,468	6,662	1,909	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	AMBULANCE SERVICES	5,727	0	163	0	0	95.00
101.00	HOME HEALTH AGENCY	60	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	367,062	175,014	35,438	33,178	33,516	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	79	1,002	0	202	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	2,360	29,819	0	6,010	0	192.00
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	MARKETING	6,537	526	0	106	0	194.00
194.01	FOUNDATION	871	324	0	65	0	194.01
194.02	COMMUNITY OUTREACH	3,827	0	0	570	0	194.02
194.03	WIC	3,438	0	170	541	0	194.03
194.04	GRANTS	2,040	0	0	313	0	194.04
194.05	VACANT SPACE	358	0	0	0	0	194.05
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	386,572	206,685	35,608	40,985	33,516	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151335

Period:
From 07/01/2010
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Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
	11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS						
1.00						1.00
2.00						2.00
4.00						4.00
5.00						5.00
7.00						7.00
8.00						8.00
9.00						9.00
10.00						10.00
11.00	79,768					11.00
13.00	619	20,901				13.00
14.00	1,251	0	47,231			14.00
15.00	2,233	0	2,077	56,708		15.00
16.00	8,948	0	0	0	127,571	16.00
17.00	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	16,214	9,086	4,692	0	5,098	30.00
31.00	5,493	3,078	1,554	0	3,290	31.00
42.00	0	0	0	0	0	42.00
43.00	1,116	625	0	0	831	43.00
44.00	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00	5,874	3,291	22,679	0	15,807	50.00
51.00	0	0	0	0	0	51.00
52.00	2,665	1,493	0	0	1,942	52.00
53.00	38	0	0	0	361	53.00
54.00	5,927	0	1,670	0	28,748	54.00
57.00	0	0	0	0	0	57.00
58.00	0	0	0	0	0	58.00
59.00	1,775	0	10,602	0	11,037	59.00
60.00	8,133	0	1,626	0	22,475	60.00
64.00	0	0	0	0	0	64.00
65.00	2,820	0	120	0	5,568	65.00
66.00	1,919	0	248	0	3,008	66.00
67.00	0	0	0	0	0	67.00
68.00	0	0	0	0	0	68.00
69.00	1,400	0	169	0	5,603	69.00
70.00	0	0	0	0	0	70.00
71.00	0	0	0	0	0	71.00
72.00	0	0	0	0	0	72.00
73.00	0	0	0	56,708	11,521	73.00
74.00	0	0	0	0	0	74.00
76.97	700	0	23	0	432	76.97
OUTPATIENT SERVICE COST CENTERS						
91.00	5,940	3,328	1,563	0	10,559	91.00
92.00						92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	2,457	0	117	0	1,291	95.00
101.00	17	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
118.00	75,539	20,901	47,140	56,708	127,571	118.00
NONREIMBURSABLE COST CENTERS						
190.00	0	0	0	0	0	190.00
192.00	0	0	0	0	0	192.00
193.00	0	0	0	0	0	193.00
194.00	264	0	0	0	0	194.00
194.01	395	0	0	0	0	194.01
194.02	1,417	0	45	0	0	194.02
194.03	1,370	0	1	0	0	194.03
194.04	783	0	45	0	0	194.04
194.05	0	0	0	0	0	194.05
200.00						200.00
201.00	0	0	0	0	0	201.00
202.00	79,768	20,901	47,231	56,708	127,571	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151335

Period:
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Cost Center Description		SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	EMPLOYEE BENEFITS					4.00
5.00	ADMINISTRATIVE & GENERAL					5.00
7.00	OPERATION OF PLANT					7.00
8.00	LAUNDRY & LINEN SERVICE					8.00
9.00	HOUSEKEEPING					9.00
10.00	DIETARY					10.00
11.00	CAFETERIA					11.00
13.00	NURSING ADMINISTRATION					13.00
14.00	CENTRAL SERVICES & SUPPLY					14.00
15.00	PHARMACY					15.00
16.00	MEDICAL RECORDS & LIBRARY					16.00
17.00	SOCIAL SERVICE	0				17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	0	269,459	0	269,459	30.00
31.00	INTENSIVE CARE UNIT	0	99,835	0	99,835	31.00
42.00	SUBPROVIDER	0	0	0	0	42.00
43.00	NURSERY	0	15,545	0	15,545	43.00
44.00	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	313,743	0	313,743	50.00
51.00	RECOVERY ROOM	0	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	125,721	0	125,721	52.00
53.00	ANESTHESIOLOGY	0	5,161	0	5,161	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	425,630	0	425,630	54.00
57.00	CT SCAN	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	92,627	0	92,627	59.00
60.00	LABORATORY	0	194,992	0	194,992	60.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	0	45,446	0	45,446	65.00
66.00	PHYSICAL THERAPY	0	59,764	0	59,764	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	41,265	0	41,265	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	68,229	0	68,229	73.00
74.00	RENAL DIALYSIS	0	0	0	0	74.00
76.97	CARDIAC REHABILITATION	0	17,090	0	17,090	76.97
OUTPATIENT SERVICE COST CENTERS						
91.00	EMERGENCY	0	121,615	0	121,615	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0	62,587	0	62,587	95.00
101.00	HOME HEALTH AGENCY	0	89	0	89	101.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	1,958,798	0	1,958,798	118.00
NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6,496	0	6,496	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	193,330	0	193,330	192.00
193.00	NONPAID WORKERS	0	0	0	0	193.00
194.00	MARKETING	0	10,279	0	10,279	194.00
194.01	FOUNDATION	0	3,511	0	3,511	194.01
194.02	COMMUNITY OUTREACH	0	21,218	0	21,218	194.02
194.03	WIC	0	59,761	0	59,761	194.03
194.04	GRANTS	0	11,591	0	11,591	194.04
194.05	VACANT SPACE	0	23,912	0	23,912	194.05
200.00	Cross Foot Adjustments	0	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	2,288,896	0	2,288,896	202.00

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)					
	1.00	2.00	4.00				
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	190,901					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		190,901				2.00
4.00	EMPLOYEE BENEFITS	6,321	6,321	12,628,743			4.00
5.00	ADMINISTRATIVE & GENERAL	28,615	28,615	1,369,422	-5,584,902	25,409,536	5.00
7.00	OPERATION OF PLANT	19,808	19,808	377,947	0	1,994,834	7.00
8.00	LAUNDRY & LINEN SERVICE	3,284	3,284	75,592	0	173,275	8.00
9.00	HOUSEKEEPING	3,218	3,218	289,126	0	489,406	9.00
10.00	DIETARY	2,752	2,752	117,947	0	301,339	10.00
11.00	CAFETERIA	7,116	7,116	185,229	0	389,996	11.00
13.00	NURSING ADMINISTRATION	1,609	1,609	102,714	0	219,055	13.00
14.00	CENTRAL SERVICES & SUPPLY	4,056	4,056	123,142	0	233,743	14.00
15.00	PHARMACY	2,526	2,526	403,737	0	1,628,574	15.00
16.00	MEDICAL RECORDS & LIBRARY	7,680	7,680	784,867	0	1,427,386	16.00
17.00	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	12,354	12,354	1,920,081	0	2,877,567	30.00
31.00	INTENSIVE CARE UNIT	4,211	4,211	1,067,935	0	1,565,533	31.00
42.00	SUBPROVIDER	0	0	0	0	0	42.00
43.00	NURSERY	751	751	174,780	0	256,065	43.00
44.00	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	11,242	11,242	823,399	0	2,208,065	50.00
51.00	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	10,343	10,343	417,299	0	682,686	52.00
53.00	ANESTHESIOLOGY	377	377	31,482	0	49,965	53.00
54.00	RADIOLOGY-DIAGNOSTIC	9,217	9,217	757,297	0	1,682,065	54.00
57.00	CT SCAN	0	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	3,921	3,921	385,090	0	1,652,551	59.00
60.00	LABORATORY	7,665	7,665	787,294	0	2,558,040	60.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	2,267	2,267	481,425	0	715,958	65.00
66.00	PHYSICAL THERAPY	4,494	4,494	279,001	0	424,792	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	2,839	2,839	152,397	0	257,218	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	CARDIAC REHABILITATION	1,343	1,343	78,601	0	119,503	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	EMERGENCY	5,906	5,906	801,014	0	1,839,128	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	AMBULANCE SERVICES	0	0	215,203	0	376,404	95.00
101.00	HOME HEALTH AGENCY	0	0	2,946	0	3,960	101.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	163,915	163,915	12,204,967	-5,584,902	24,127,108	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	625	625	0	0	5,213	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	18,600	18,600	0	0	155,141	192.00
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	MARKETING	328	328	26,257	0	429,644	194.00
194.01	FOUNDATION	202	202	41,034	0	57,231	194.01
194.02	COMMUNITY OUTREACH	1,763	1,763	156,962	0	251,540	194.02
194.03	WIC	1,675	1,675	121,054	0	225,991	194.03
194.04	GRANTS	969	969	78,469	0	134,114	194.04
194.05	VACANT SPACE	2,824	2,824	0	0	23,554	194.05
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per wkst. B, Part I)	899,766	692,516	4,024,959		5,584,902	202.00
203.00	Unit cost multiplier (wkst. B, Part I)	4.713260	3.627619	0.318714		0.219796	203.00
204.00	Cost to be allocated (per wkst. B, Part II)			52,723		386,572	204.00
205.00	Unit cost multiplier (wkst. B, Part II)			0.004175		0.015214	205.00

Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (PAID HOURS)	
	7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	EMPLOYEE BENEFITS					4.00
5.00	ADMINISTRATIVE & GENERAL					5.00
7.00	OPERATION OF PLANT	128,926				7.00
8.00	LAUNDRY & LINEN SERVICE	3,284	5,035			8.00
9.00	HOUSEKEEPING	3,218	47	126,831		9.00
10.00	DIETARY	2,752	26	2,752	4,785	10.00
11.00	CAFETERIA	7,116	0	7,116	0	11.00
13.00	NURSING ADMINISTRATION	1,609	0	1,609	0	13.00
14.00	CENTRAL SERVICES & SUPPLY	4,056	0	4,056	0	14.00
15.00	PHARMACY	2,526	0	2,526	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	7,680	0	7,680	0	16.00
17.00	SOCIAL SERVICE	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	12,354	1,889	12,354	3,670	30.00
31.00	INTENSIVE CARE UNIT	4,211	544	4,211	1,115	31.00
42.00	SUBPROVIDER	0	0	0	0	42.00
43.00	NURSERY	751	90	751	0	43.00
44.00	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	11,242	715	11,242	0	50.00
51.00	RECOVERY ROOM	0	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	10,343	184	10,343	0	52.00
53.00	ANESTHESIOLOGY	377	0	377	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	9,217	280	9,217	0	54.00
57.00	CT SCAN	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	3,921	104	3,921	0	59.00
60.00	LABORATORY	7,665	0	7,665	0	60.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	2,267	0	2,267	0	65.00
66.00	PHYSICAL THERAPY	4,494	111	4,494	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	2,839	56	2,839	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	RENAL DIALYSIS	0	0	0	0	74.00
76.97	CARDIAC REHABILITATION	1,343	0	1,343	0	76.97
OUTPATIENT SERVICE COST CENTERS						
91.00	EMERGENCY	5,906	942	5,906	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0	23	0	0	95.00
101.00	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	109,171	5,011	102,669	4,785	118.00
NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	625	0	625	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	18,600	0	18,600	0	192.00
193.00	NONPAID WORKERS	0	0	0	0	193.00
194.00	MARKETING	328	0	328	0	194.00
194.01	FOUNDATION	202	0	202	0	194.01
194.02	COMMUNITY OUTREACH	0	0	1,763	0	194.02
194.03	WIC	0	24	1,675	0	194.03
194.04	GRANTS	0	0	969	0	194.04
194.05	VACANT SPACE	0	0	0	0	194.05
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	2,433,291	273,341	660,262	435,249	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	18.873548	54.288183	5.205841	90.961129	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	206,685	35,608	40,985	33,516	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	1.603129	7.072095	0.323147	7.004389	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151335

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

Worksheet B-1

Date/Time Prepared:
1/30/2012 5:43 pm

Cost Center Description		NURSING ADMINISTRATION (PAID HOURS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	
		13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
7.00	OPERATION OF PLANT						7.00
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING						9.00
10.00	DIETARY						10.00
11.00	CAFETERIA						11.00
13.00	NURSING ADMINISTRATION	197,117					13.00
14.00	CENTRAL SERVICES & SUPPLY	0	944,875				14.00
15.00	PHARMACY	0	41,554	100			15.00
16.00	MEDICAL RECORDS & LIBRARY	0	0	0	58,116,064		16.00
17.00	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	85,675	93,874	0	2,322,742	0	30.00
31.00	INTENSIVE CARE UNIT	29,029	31,097	0	1,498,656	0	31.00
42.00	SUBPROVIDER	0	0	0	0	0	42.00
43.00	NURSERY	5,899	0	0	378,400	0	43.00
44.00	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	31,039	453,708	0	7,201,332	0	50.00
51.00	RECOVERY ROOM			0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	14,085	0	0	884,588	0	52.00
53.00	ANESTHESIOLOGY	0	0	0	164,346	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	33,407	0	13,093,927	0	54.00
57.00	CT SCAN	0	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	212,090	0	5,028,322	0	59.00
60.00	LABORATORY	0	32,533	0	10,239,267	0	60.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	0	2,401	0	2,536,669	0	65.00
66.00	PHYSICAL THERAPY	0	4,970	0	1,370,501	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	3,373	0	2,552,742	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	100	5,248,837	0	73.00
74.00	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	CARDIAC REHABILITATION	0	451	0	196,892	0	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	EMERGENCY	31,390	31,265	0	4,810,476	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	AMBULANCE SERVICES	0	2,335	0	588,367	0	95.00
101.00	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	197,117	943,058	100	58,116,064	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	MARKETING	0	0	0	0	0	194.00
194.01	FOUNDATION	0	0	0	0	0	194.01
194.02	COMMUNITY OUTREACH	0	907	0	0	0	194.02
194.03	WIC	0	16	0	0	0	194.03
194.04	GRANTS	0	894	0	0	0	194.04
194.05	VACANT SPACE	0	0	0	0	0	194.05
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	310,969	392,937	2,082,751	1,998,635	0	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	1.577586	0.415861	20,827.510000	0.034390	0.000000	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	20,901	47,231	56,708	127,571	0	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.106033	0.049987	567.080000	0.002195	0.000000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151335

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

Worksheet C
Part I
Date/Time Prepared:
1/30/2012 5:43 pm

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
				Total Costs	RCE Disallowance		Total Costs	
				1.00	2.00		3.00	4.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	4,629,481			4,629,481	0	0	30.00
31.00	INTENSIVE CARE UNIT	2,296,814			2,296,814	0	0	31.00
42.00	SUBPROVIDER	0			0	0	0	42.00
43.00	NURSERY	366,692			366,692	0	0	43.00
44.00	SKILLED NURSING FACILITY	0			0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	OPERATING ROOM	3,535,852			3,535,852	0	0	50.00
51.00	RECOVERY ROOM	0			0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	1,166,043			1,166,043	0	0	52.00
53.00	ANESTHESIOLOGY	75,986			75,986	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	2,801,211			2,801,211	0	0	54.00
57.00	CT SCAN	0			0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0			0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	2,391,355			2,391,355	0	0	59.00
60.00	LABORATORY	3,736,485			3,736,485	0	0	60.00
64.00	INTRAVENOUS THERAPY	0			0	0	0	64.00
65.00	RESPIRATORY THERAPY	1,039,021	0		1,039,021	0	0	65.00
66.00	PHYSICAL THERAPY	697,161	0		697,161	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0		0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0		0	0	0	68.00
69.00	ELECTROCARDIOLOGY	485,701			485,701	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0			0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0			0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0			0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	2,263,259			2,263,259	0	0	73.00
74.00	RENAL DIALYSIS	0			0	0	0	74.00
76.97	CARDIAC REHABILITATION	190,743			190,743	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	EMERGENCY	2,712,854			2,712,854	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	908,743			908,743	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	AMBULANCE SERVICES	501,519			501,519	0	0	95.00
101.00	HOME HEALTH AGENCY	4,971			4,971	0	0	101.00
200.00	Subtotal (see instructions)	29,803,891	0		29,803,891	0	0	200.00
201.00	Less Observation Beds	908,743			908,743	0	0	201.00
202.00	Total (see instructions)	28,895,148	0		28,895,148	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151335

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

Worksheet C
Part I
Date/Time Prepared:
1/30/2012 5:43 pm

Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	Cost
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	2,322,742		2,322,742			30.00
31.00 INTENSIVE CARE UNIT	1,498,656		1,498,656			31.00
42.00 SUBPROVIDER	0		0			42.00
43.00 NURSERY	378,400		378,400			43.00
44.00 SKILLED NURSING FACILITY	0		0			44.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	1,574,613	5,626,718	7,201,331	0.491000	0.000000	50.00
51.00 RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00 DELIVERY ROOM & LABOR ROOM	881,407	3,181	884,588	1.318176	0.000000	52.00
53.00 ANESTHESIOLOGY	29,642	134,704	164,346	0.462354	0.000000	53.00
54.00 RADIOLOGY-DIAGNOSTIC	1,056,677	12,037,250	13,093,927	0.213932	0.000000	54.00
57.00 CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
59.00 CARDIAC CATHETERIZATION	2,303,921	2,724,402	5,028,323	0.475577	0.000000	59.00
60.00 LABORATORY	1,689,270	8,549,997	10,239,267	0.364917	0.000000	60.00
64.00 INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
65.00 RESPIRATORY THERAPY	1,488,158	1,048,511	2,536,669	0.409601	0.000000	65.00
66.00 PHYSICAL THERAPY	47,461	1,323,040	1,370,501	0.508691	0.000000	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00 SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00 ELECTROCARDIOLOGY	662,221	1,890,521	2,552,742	0.190266	0.000000	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00 DRUGS CHARGED TO PATIENTS	2,997,041	2,251,798	5,248,839	0.431192	0.000000	73.00
74.00 RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
76.97 CARDIAC REHABILITATION	393	196,498	196,891	0.968775	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS						
91.00 EMERGENCY	245,567	4,564,909	4,810,476	0.563947	0.000000	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	794,155	794,155	1.144289	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 AMBULANCE SERVICES	0	588,367	588,367	0.852391	0.000000	95.00
101.00 HOME HEALTH AGENCY	0	0	0			101.00
200.00 Subtotal (see instructions)	17,176,169	41,734,051	58,910,220			200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	17,176,169	41,734,051	58,910,220			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 151335	Period: From 07/01/2010 To 06/30/2011	Worksheet C Part I Date/Time Prepared: 1/30/2012 5:43 pm
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Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS				30.00
31.00	INTENSIVE CARE UNIT				31.00
42.00	SUBPROVIDER				42.00
43.00	NURSERY				43.00
44.00	SKILLED NURSING FACILITY				44.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.000000			50.00
51.00	RECOVERY ROOM	0.000000			51.00
52.00	DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	ANESTHESIOLOGY	0.000000			53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
57.00	CT SCAN	0.000000			57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000			58.00
59.00	CARDIAC CATHETERIZATION	0.000000			59.00
60.00	LABORATORY	0.000000			60.00
64.00	INTRAVENOUS THERAPY	0.000000			64.00
65.00	RESPIRATORY THERAPY	0.000000			65.00
66.00	PHYSICAL THERAPY	0.000000			66.00
67.00	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	SPEECH PATHOLOGY	0.000000			68.00
69.00	ELECTROCARDIOLOGY	0.000000			69.00
70.00	ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	DRUGS CHARGED TO PATIENTS	0.000000			73.00
74.00	RENAL DIALYSIS	0.000000			74.00
76.97	CARDIAC REHABILITATION	0.000000			76.97
OUTPATIENT SERVICE COST CENTERS					
91.00	EMERGENCY	0.000000			91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	AMBULANCE SERVICES	0.000000			95.00
101.00	HOME HEALTH AGENCY				101.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151335

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

Worksheet C
Part I
Date/Time Prepared:
1/30/2012 5:43 pm

Cost Center Description		Total Cost (from wkst. B, Part I, col. 26)	Therapy Limit Adj.	Title XIX		Hospital		Total Costs	
				Total Costs	RCE	Disallowance	Total Costs		
				1.00	2.00	3.00	4.00		5.00
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	ADULTS & PEDIATRICS	4,629,481						0	30.00
31.00	INTENSIVE CARE UNIT	2,296,814						0	31.00
42.00	SUBPROVIDER	0						0	42.00
43.00	NURSERY	366,692						0	43.00
44.00	SKILLED NURSING FACILITY	0						0	44.00
ANCILLARY SERVICE COST CENTERS									
50.00	OPERATING ROOM	3,535,852						0	50.00
51.00	RECOVERY ROOM	0						0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	1,166,043						0	52.00
53.00	ANESTHESIOLOGY	75,986						0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	2,801,211						0	54.00
57.00	CT SCAN	0						0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0						0	58.00
59.00	CARDIAC CATHETERIZATION	2,391,355						0	59.00
60.00	LABORATORY	3,736,485						0	60.00
64.00	INTRAVENOUS THERAPY	0						0	64.00
65.00	RESPIRATORY THERAPY	1,039,021	0					0	65.00
66.00	PHYSICAL THERAPY	697,161	0					0	66.00
67.00	OCCUPATIONAL THERAPY	0	0					0	67.00
68.00	SPEECH PATHOLOGY	0	0					0	68.00
69.00	ELECTROCARDIOLOGY	485,701						0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0						0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0						0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0						0	72.00
73.00	DRUGS CHARGED TO PATIENTS	2,263,259						0	73.00
74.00	RENAL DIALYSIS	0						0	74.00
76.97	CARDIAC REHABILITATION	190,743						0	76.97
OUTPATIENT SERVICE COST CENTERS									
91.00	EMERGENCY	2,712,854						0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	908,743						0	92.00
OTHER REIMBURSABLE COST CENTERS									
95.00	AMBULANCE SERVICES	501,519						0	95.00
101.00	HOME HEALTH AGENCY	4,971						0	101.00
200.00	Subtotal (see instructions)	29,803,891	0					0	200.00
201.00	Less Observation Beds	908,743						0	201.00
202.00	Total (see instructions)	28,895,148	0					0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151335

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

Worksheet C
Part I
Date/Time Prepared:
1/30/2012 5:43 pm

Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	Cost
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	2,322,742		2,322,742			30.00
31.00 INTENSIVE CARE UNIT	1,498,656		1,498,656			31.00
42.00 SUBPROVIDER	0		0			42.00
43.00 NURSERY	378,400		378,400			43.00
44.00 SKILLED NURSING FACILITY	0		0			44.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	1,574,613	5,626,718	7,201,331	0.491000	0.000000	50.00
51.00 RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00 DELIVERY ROOM & LABOR ROOM	881,407	3,181	884,588	1.318176	0.000000	52.00
53.00 ANESTHESIOLOGY	29,642	134,704	164,346	0.462354	0.000000	53.00
54.00 RADIOLOGY-DIAGNOSTIC	1,056,677	12,037,250	13,093,927	0.213932	0.000000	54.00
57.00 CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
59.00 CARDIAC CATHETERIZATION	230,392	2,724,402	2,954,794	0.809314	0.000000	59.00
60.00 LABORATORY	18,270	8,549,997	8,568,267	0.436084	0.000000	60.00
64.00 INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
65.00 RESPIRATORY THERAPY	488,158	1,048,511	1,536,669	0.676151	0.000000	65.00
66.00 PHYSICAL THERAPY	47,461	1,323,040	1,370,501	0.508691	0.000000	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00 SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00 ELECTROCARDIOLOGY	662,221	1,890,521	2,552,742	0.190266	0.000000	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00 DRUGS CHARGED TO PATIENTS	2,997,041	2,251,798	5,248,839	0.431192	0.000000	73.00
74.00 RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
76.97 CARDIAC REHABILITATION	393	196,498	196,891	0.968775	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS						
91.00 EMERGENCY	245,567	4,564,909	4,810,476	0.563947	0.000000	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	794,155	794,155	1.144289	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 AMBULANCE SERVICES	0	588,367	588,367	0.852391	0.000000	95.00
101.00 HOME HEALTH AGENCY	0	0	0			101.00
200.00 Subtotal (see instructions)	12,431,640	41,734,051	54,165,691			200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	12,431,640	41,734,051	54,165,691			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 151335	Period: From 07/01/2010 To 06/30/2011	Worksheet C Part I Date/Time Prepared: 1/30/2012 5:43 pm
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Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS				30.00
31.00	INTENSIVE CARE UNIT				31.00
42.00	SUBPROVIDER				42.00
43.00	NURSERY				43.00
44.00	SKILLED NURSING FACILITY				44.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.000000			50.00
51.00	RECOVERY ROOM	0.000000			51.00
52.00	DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	ANESTHESIOLOGY	0.000000			53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
57.00	CT SCAN	0.000000			57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000			58.00
59.00	CARDIAC CATHETERIZATION	0.000000			59.00
60.00	LABORATORY	0.000000			60.00
64.00	INTRAVENOUS THERAPY	0.000000			64.00
65.00	RESPIRATORY THERAPY	0.000000			65.00
66.00	PHYSICAL THERAPY	0.000000			66.00
67.00	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	SPEECH PATHOLOGY	0.000000			68.00
69.00	ELECTROCARDIOLOGY	0.000000			69.00
70.00	ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	DRUGS CHARGED TO PATIENTS	0.000000			73.00
74.00	RENAL DIALYSIS	0.000000			74.00
76.97	CARDIAC REHABILITATION	0.000000			76.97
OUTPATIENT SERVICE COST CENTERS					
91.00	EMERGENCY	0.000000			91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	AMBULANCE SERVICES	0.000000			95.00
101.00	HOME HEALTH AGENCY				101.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 151335	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part II Date/Time Prepared: 1/30/2012 5:43 pm
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Cost Center Description	Title XVIII			Hospital	Cost		
	Capital Related Cost (from wkst. B, Part II, col. 26)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
	1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	313,743	7,201,331	0.043567	896,433	39,055	50.00
51.00	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	125,721	884,588	0.142124	5,541	788	52.00
53.00	ANESTHESIOLOGY	5,161	164,346	0.031403	11,291	355	53.00
54.00	RADIOLOGY-DIAGNOSTIC	425,630	13,093,927	0.032506	835,777	27,168	54.00
57.00	CT SCAN	0	0	0.000000	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	CARDIAC CATHETERIZATION	92,627	5,028,323	0.018421	604,190	11,130	59.00
60.00	LABORATORY	194,992	10,239,267	0.019044	1,055,657	20,104	60.00
64.00	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	RESPIRATORY THERAPY	45,446	2,536,669	0.017916	319,237	5,719	65.00
66.00	PHYSICAL THERAPY	59,764	1,370,501	0.043607	43,710	1,906	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	ELECTROCARDIOLOGY	41,265	2,552,742	0.016165	628,090	10,153	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	68,229	5,248,839	0.012999	1,789,179	23,258	73.00
74.00	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
76.97	CARDIAC REHABILITATION	17,090	196,891	0.086799	199	17	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	EMERGENCY	121,615	4,810,476	0.025281	16,323	413	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	794,155	0.000000	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	1,511,283	54,122,055		6,205,627	140,066	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151335

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

Worksheet D
Part IV
Date/Time Prepared:
1/30/2012 5:43 pm

Cost Center Description	Title XVIII				Hospital	Cost	
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)		
	1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	0	0	0	0	0	50.00
51.00	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	CT SCAN	0	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	0	0	0	0	0	60.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS.	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	EMERGENCY	0	0	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151335

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

Worksheet D
Part IV
Date/Time Prepared:
1/30/2012 5:43 pm

Cost Center Description	Title XVIII			Hospital		Cost
	Total	Total Charges	Ratio of Cost	Outpatient	Inpatient	
	Outpatient Cost (sum of col. 2, 3 and 4)	(from wkst. C, Part I, col. 8)	to Charges (col. 5 ÷ col. 7)	Ratio of Cost to Charges (col. 6 ÷ col. 7)	Program Charges	
6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	7,201,331	0.000000	0.000000	896,433 50.00
51.00	RECOVERY ROOM	0	0	0.000000	0.000000	0 51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	884,588	0.000000	0.000000	5,541 52.00
53.00	ANESTHESIOLOGY	0	164,346	0.000000	0.000000	11,291 53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	13,093,927	0.000000	0.000000	835,777 54.00
57.00	CT SCAN	0	0	0.000000	0.000000	0 57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0 58.00
59.00	CARDIAC CATHETERIZATION	0	5,028,323	0.000000	0.000000	604,190 59.00
60.00	LABORATORY	0	10,239,267	0.000000	0.000000	1,055,657 60.00
64.00	INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0 64.00
65.00	RESPIRATORY THERAPY	0	2,536,669	0.000000	0.000000	319,237 65.00
66.00	PHYSICAL THERAPY	0	1,370,501	0.000000	0.000000	43,710 66.00
67.00	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0 67.00
68.00	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0 68.00
69.00	ELECTROCARDIOLOGY	0	2,552,742	0.000000	0.000000	628,090 69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0 70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0.000000	0 71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0.000000	0 72.00
73.00	DRUGS CHARGED TO PATIENTS	0	5,248,839	0.000000	0.000000	1,789,179 73.00
74.00	RENAL DIALYSIS	0	0	0.000000	0.000000	0 74.00
76.97	CARDIAC REHABILITATION	0	196,891	0.000000	0.000000	199 76.97
OUTPATIENT SERVICE COST CENTERS						
91.00	EMERGENCY	0	4,810,476	0.000000	0.000000	16,323 91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	794,155	0.000000	0.000000	0 92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES					
200.00	Total (lines 50-199)	0	54,122,055			6,205,627 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151335

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

Worksheet D
Part IV
Date/Time Prepared:
1/30/2012 5:43 pm

Cost Center Description	Title XVIII			Hospital	Cost
	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School
	11.00	12.00	13.00	21.00	22.00
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	0	0	0	0	0
51.00 RECOVERY ROOM	0	0	0	0	0
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0
53.00 ANESTHESIOLOGY	0	0	0	0	0
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0
57.00 CT SCAN	0	0	0	0	0
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0
60.00 LABORATORY	0	0	0	0	0
64.00 INTRAVENOUS THERAPY	0	0	0	0	0
65.00 RESPIRATORY THERAPY	0	0	0	0	0
66.00 PHYSICAL THERAPY	0	0	0	0	0
67.00 OCCUPATIONAL THERAPY	0	0	0	0	0
68.00 SPEECH PATHOLOGY	0	0	0	0	0
69.00 ELECTROCARDIOLOGY	0	0	0	0	0
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0
74.00 RENAL DIALYSIS	0	0	0	0	0
76.97 CARDIAC REHABILITATION	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS					
91.00 EMERGENCY	0	0	0	0	0
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS					
95.00 AMBULANCE SERVICES					
200.00 Total (lines 50-199)	0	0	0	0	0

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151335	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part IV Date/Time Prepared: 1/30/2012 5:43 pm
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Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	Title XVIII	Hospital	Cost
		23.00	24.00			
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	0			50.00
51.00	RECOVERY ROOM	0	0			51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0			52.00
53.00	ANESTHESIOLOGY	0	0			53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0			54.00
57.00	CT SCAN	0	0			57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0			58.00
59.00	CARDIAC CATHETERIZATION	0	0			59.00
60.00	LABORATORY	0	0			60.00
64.00	INTRAVENOUS THERAPY	0	0			64.00
65.00	RESPIRATORY THERAPY	0	0			65.00
66.00	PHYSICAL THERAPY	0	0			66.00
67.00	OCCUPATIONAL THERAPY	0	0			67.00
68.00	SPEECH PATHOLOGY	0	0			68.00
69.00	ELECTROCARDIOLOGY	0	0			69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0			70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0			72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0			73.00
74.00	RENAL DIALYSIS	0	0			74.00
76.97	CARDIAC REHABILITATION	0	0			76.97
OUTPATIENT SERVICE COST CENTERS						
91.00	EMERGENCY	0	0			91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0			92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES					95.00
200.00	Total (lines 50-199)	0	0			200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151335	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part V Date/Time Prepared: 1/30/2012 5:43 pm
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Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Cost	
		PPS Reimbursed Services (see instructions)	Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)		
			1.00	2.00		3.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0.491000	0	1,909,290	0	50.00
51.00	RECOVERY ROOM	0.000000	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	1.318176	0	3,181	0	52.00
53.00	ANESTHESIOLOGY	0.462354	0	44,016	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.213932	0	4,590,052	0	54.00
57.00	CT SCAN	0.000000	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0.475577	0	920,368	0	59.00
60.00	LABORATORY	0.364917	0	3,029,066	0	60.00
64.00	INTRAVENOUS THERAPY	0.000000	0	0	0	64.00
65.00	RESPIRATORY THERAPY	0.409601	0	57,777	0	65.00
66.00	PHYSICAL THERAPY	0.508691	0	377,704	0	66.00
67.00	OCCUPATIONAL THERAPY	0.000000	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0.000000	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0.190266	0	1,000,488	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.431192	0	869,279	4,168	73.00
74.00	RENAL DIALYSIS	0.000000	0	0	0	74.00
76.97	CARDIAC REHABILITATION	0.968775	0	100,151	0	76.97
OUTPATIENT SERVICE COST CENTERS						
91.00	EMERGENCY	0.563947	0	1,662,793	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.144289	0	516,824	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES	0.852391	0	0	0	95.00
200.00	Subtotal (see instructions)		0	15,080,989	4,168	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges		0	0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		0	15,080,989	4,168	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151335	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part V Date/Time Prepared: 1/30/2012 5:43 pm
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Cost Center Description	Title XVIII			Hospital	Cost
	Costs				
	PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)		
	5.00	6.00	7.00		
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	0	937,461	0		50.00
51.00 RECOVERY ROOM	0	0	0		51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	4,193	0		52.00
53.00 ANESTHESIOLOGY	0	20,351	0		53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	981,959	0		54.00
57.00 CT SCAN	0	0	0		57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00 CARDIAC CATHETERIZATION	0	437,706	0		59.00
60.00 LABORATORY	0	1,105,358	0		60.00
64.00 INTRAVENOUS THERAPY	0	0	0		64.00
65.00 RESPIRATORY THERAPY	0	23,666	0		65.00
66.00 PHYSICAL THERAPY	0	192,135	0		66.00
67.00 OCCUPATIONAL THERAPY	0	0	0		67.00
68.00 SPEECH PATHOLOGY	0	0	0		68.00
69.00 ELECTROCARDIOLOGY	0	190,359	0		69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	0	374,826	1,797		73.00
74.00 RENAL DIALYSIS	0	0	0		74.00
76.97 CARDIAC REHABILITATION	0	97,024	0		76.97
OUTPATIENT SERVICE COST CENTERS					
91.00 EMERGENCY	0	937,727	0		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	591,396	0		92.00
OTHER REIMBURSABLE COST CENTERS					
95.00 AMBULANCE SERVICES		0			95.00
200.00 Subtotal (see instructions)	0	5,894,161	1,797		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00 Net Charges (line 200 +/- line 201)	0	5,894,161	1,797		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS	Provider CCN: 151335	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part I Date/Time Prepared: 1/30/2012 5:43 pm
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Cost Center Description	Title XIX			Hospital	Cost		
	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)		
	1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	269,459	0	269,459	4,534	59.43	30.00
31.00	INTENSIVE CARE UNIT	99,835		99,835	1,115	89.54	31.00
42.00	SUBPROVIDER	0	0	0	0	0.00	42.00
43.00	NURSERY	15,545		15,545	628	24.75	43.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
200.00	Total (lines 30-199)	384,839		384,839	6,277		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS	Provider CCN: 151335	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part I Date/Time Prepared: 1/30/2012 5:43 pm
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Cost Center Description	Title XIX		Hospital	Cost
	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)		
	6.00	7.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00 ADULTS & PEDIATRICS	613	36,431		30.00
31.00 INTENSIVE CARE UNIT	91	8,148		31.00
42.00 SUBPROVIDER	0	0		42.00
43.00 NURSERY	83	2,054		43.00
44.00 SKILLED NURSING FACILITY	0	0		44.00
200.00 Total (lines 30-199)	787	46,633		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 151335	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part II Date/Time Prepared: 1/30/2012 5:43 pm
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Cost Center Description	Title XIX			Hospital	Cost	
	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	313,743	7,201,331	0.043567	64,577	2,813	50.00
51.00 RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00 DELIVERY ROOM & LABOR ROOM	125,721	884,588	0.142124	47,609	6,766	52.00
53.00 ANESTHESIOLOGY	5,161	164,346	0.031403	1,662	52	53.00
54.00 RADIOLOGY-DIAGNOSTIC	425,630	13,093,927	0.032506	64,401	2,093	54.00
57.00 CT SCAN	0	0	0.000000	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00 CARDIAC CATHETERIZATION	92,627	2,954,794	0.031348	140,144	4,393	59.00
60.00 LABORATORY	194,992	8,568,267	0.022757	90,763	2,065	60.00
64.00 INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00 RESPIRATORY THERAPY	45,446	1,536,669	0.029574	90,843	2,687	65.00
66.00 PHYSICAL THERAPY	59,764	1,370,501	0.043607	1,754	76	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00 ELECTROCARDIOLOGY	41,265	2,552,742	0.016165	34,131	552	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	68,229	5,248,839	0.012999	188,811	2,454	73.00
74.00 RENAL DIALYSIS	0	0	0.000000	0	0	74.00
76.97 CARDIAC REHABILITATION	17,090	196,891	0.086799	194	17	76.97
OUTPATIENT SERVICE COST CENTERS						
91.00 EMERGENCY	121,615	4,810,476	0.025281	41,272	1,043	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	794,155	0.000000	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 AMBULANCE SERVICES						95.00
200.00 Total (lines 50-199)	1,511,283	49,377,526		766,161	25,011	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151335	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part III Date/Time Prepared: 1/30/2012 5:43 pm
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Cost Center Description	Title XIX				Hospital	Cost
	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 5, minus col. 4)	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00 INTENSIVE CARE UNIT	0	0	0	0	0	31.00
42.00 SUBPROVIDER	0	0	0	0	0	42.00
43.00 NURSERY	0	0	0	0	0	43.00
44.00 SKILLED NURSING FACILITY	0	0	0	0	0	44.00
200.00 Total (lines 30-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151335

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

Worksheet D
Part III
Date/Time Prepared:
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Cost Center Description	Total Patient Days	Title XIX			Hospital Cost	
		Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. Nursing School	
	6.00	7.00	8.00	9.00	11.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	4,534	0.00	613	0	0	30.00
31.00 INTENSIVE CARE UNIT	1,115	0.00	91	0	0	31.00
42.00 SUBPROVIDER	0	0.00	0	0	0	42.00
43.00 NURSERY	628	0.00	83	0	0	43.00
44.00 SKILLED NURSING FACILITY	0	0.00	0	0	0	44.00
200.00 Total (lines 30-199)	6,277		787	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151335	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part III Date/Time Prepared: 1/30/2012 5:43 pm
	Title XIX	Hospital	Cost

Cost Center Description	PSA Adj. Allied Health Cost	PSA Adj. All Other Medical Education Cost	
	12.00	13.00	
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00 ADULTS & PEDIATRICS	0	0	30.00
31.00 INTENSIVE CARE UNIT	0	0	31.00
42.00 SUBPROVIDER	0	0	42.00
43.00 NURSERY	0	0	43.00
44.00 SKILLED NURSING FACILITY	0	0	44.00
200.00 Total (lines 30-199)	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151335

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

Worksheet D
Part IV
Date/Time Prepared:
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Cost Center Description	Title XIX				Hospital	Cost
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	0	0	0	50.00
51.00	RECOVERY ROOM	0	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
57.00	CT SCAN	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	LABORATORY	0	0	0	0	60.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	RENAL DIALYSIS	0	0	0	0	74.00
76.97	CARDIAC REHABILITATION	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
91.00	EMERGENCY	0	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	AMBULANCE SERVICES					95.00
200.00	Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151335

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

Worksheet D
Part IV
Date/Time Prepared:
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Cost Center Description	Title XIX			Hospital		Cost	
	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges		
	6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	0	7,201,331	0.000000	0.000000	64,577	50.00
51.00	RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	884,588	0.000000	0.000000	47,609	52.00
53.00	ANESTHESIOLOGY	0	164,346	0.000000	0.000000	1,662	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	13,093,927	0.000000	0.000000	64,401	54.00
57.00	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
59.00	CARDIAC CATHETERIZATION	0	2,954,794	0.000000	0.000000	140,144	59.00
60.00	LABORATORY	0	8,568,267	0.000000	0.000000	90,763	60.00
64.00	INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0	64.00
65.00	RESPIRATORY THERAPY	0	1,536,669	0.000000	0.000000	90,843	65.00
66.00	PHYSICAL THERAPY	0	1,370,501	0.000000	0.000000	1,754	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	ELECTROCARDIOLOGY	0	2,552,742	0.000000	0.000000	34,131	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	5,248,839	0.000000	0.000000	188,811	73.00
74.00	RENAL DIALYSIS	0	0	0.000000	0.000000	0	74.00
76.97	CARDIAC REHABILITATION	0	196,891	0.000000	0.000000	194	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	EMERGENCY	0	4,810,476	0.000000	0.000000	41,272	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	794,155	0.000000	0.000000	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	0	49,377,526			766,161	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151335

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

Worksheet D
Part IV
Date/Time Prepared:
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Cost Center Description	Title XIX			Hospital	Cost	
	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
	11.00	12.00	13.00	21.00	22.00	
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	0	0	0	0	50.00
51.00 RECOVERY ROOM	0	0	0	0	0	51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00 CT SCAN	0	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 LABORATORY	0	0	0	0	0	60.00
64.00 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00 RENAL DIALYSIS	0	0	0	0	0	74.00
76.97 CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
91.00 EMERGENCY	0	0	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 AMBULANCE SERVICES						95.00
200.00 Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151335

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

Worksheet D
Part IV
Date/Time Prepared:
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Cost Center Description		Title XIX		Hospital	Cost
		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost		
		23.00	24.00		
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0	0		50.00
51.00	RECOVERY ROOM	0	0		51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	ANESTHESIOLOGY	0	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0		54.00
57.00	CT SCAN	0	0		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	CARDIAC CATHETERIZATION	0	0		59.00
60.00	LABORATORY	0	0		60.00
64.00	INTRAVENOUS THERAPY	0	0		64.00
65.00	RESPIRATORY THERAPY	0	0		65.00
66.00	PHYSICAL THERAPY	0	0		66.00
67.00	OCCUPATIONAL THERAPY	0	0		67.00
68.00	SPEECH PATHOLOGY	0	0		68.00
69.00	ELECTROCARDIOLOGY	0	0		69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	RENAL DIALYSIS	0	0		74.00
76.97	CARDIAC REHABILITATION	0	0		76.97
OUTPATIENT SERVICE COST CENTERS					
91.00	EMERGENCY	0	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	AMBULANCE SERVICES				95.00
200.00	Total (Lines 50-199)	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 151335	Period: From 07/01/2010 To 06/30/2011	Worksheet D-1 Date/Time Prepared: 1/30/2012 5:43 pm
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Cost Center Description	Title XVIII	Hospital	Cost
PART I - ALL PROVIDER COMPONENTS			1.00
INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		4,534 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		4,534 2.00
3.00	Private room days (excluding swing-bed and observation bed days)		0 3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		4,534 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0 5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0 7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		2,119 9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0 10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0 14.00
15.00	Total nursery days (title V or XIX only)		0 15.00
16.00	Nursery days (title V or XIX only)		0 16.00
SWING BED ADJUSTMENT			
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00 17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00 18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00 20.00
21.00	Total general inpatient routine service cost (see instructions)		4,629,481 21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0 22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0 23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0 24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0 25.00
26.00	Total swing-bed cost (see instructions)		0 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		4,629,481 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28.00	General inpatient routine service charges (excluding swing-bed charges)		2,322,742 28.00
29.00	Private room charges (excluding swing-bed charges)		0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		1.993110 31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00 32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00 33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00 34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00 35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0 36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		4,629,481 37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY			
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS			
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,021.06 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,163,626 39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0 40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		2,163,626 41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151335

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

Worksheet D-1

Date/Time Prepared:
1/30/2012 5:43 pm

Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
42.00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	2,296,814	1,115	2,059.92	748	1,540,820	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
48.00	Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					2,357,415	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					6,061,861	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					890	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,021.06	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					908,743	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 151335	Period: From 07/01/2010 To 06/30/2011	Worksheet D-1 Date/Time Prepared: 1/30/2012 5:43 pm
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Cost Center Description	Cost	Title XVIII		Hospital	
		Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)
	1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
90.00 Capital-related cost	0	0	0.000000	0	0 90.00
91.00 Nursing School cost	0	0	0.000000	0	0 91.00
92.00 Allied health cost	0	0	0.000000	0	0 92.00
93.00 All other Medical Education	0	0	0.000000	0	0 93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 151335	Period: From 07/01/2010 To 06/30/2011	Worksheet D-1 Date/Time Prepared: 1/30/2012 5:43 pm
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Cost Center Description	Title XIX	Hospital	Cost	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		4,534	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		4,534	2.00
3.00	Private room days (excluding swing-bed and observation bed days)		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		4,534	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		613	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		628	15.00
16.00	Nursery days (title V or XIX only)		83	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		4,629,481	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		4,629,481	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		2,322,742	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		1.993110	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		4,629,481	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,021.06	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		625,910	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		625,910	41.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 151335	Period: From 07/01/2010 To 06/30/2011	Worksheet D-1 Date/Time Prepared: 1/30/2012 5:43 pm
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Cost Center Description	Title XIX			Hospital		Program Cost (col. 3 x col. 4)	Cost
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
42.00 NURSERY (title V & XIX only)	366,692	628	583.90	83	48,464	42.00	
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	2,296,814	1,115	2,059.92	91	187,453	43.00	
44.00 CORONARY CARE UNIT						44.00	
45.00 BURN INTENSIVE CARE UNIT						45.00	
46.00 SURGICAL INTENSIVE CARE UNIT						46.00	
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00	
Cost Center Description							
48.00 Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					435,697	48.00	
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,297,524	49.00	
PASS THROUGH COST ADJUSTMENTS							
50.00 Pass through costs applicable to Program inpatient routine services (from wkst. D, sum of Parts I and III)					0	50.00	
51.00 Pass through costs applicable to Program inpatient ancillary services (from wkst. D, sum of Parts II and IV)					0	51.00	
52.00 Total Program excludable cost (sum of lines 50 and 51)					0	52.00	
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00	
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges					0	54.00	
55.00 Target amount per discharge					0.00	55.00	
56.00 Target amount (line 54 x line 55)					0	56.00	
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00	
58.00 Bonus payment (see instructions)					0	58.00	
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00	
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00	
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00	
62.00 Relief payment (see instructions)					0	62.00	
63.00 Allowable inpatient cost plus incentive payment (see instructions)					0	63.00	
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00	
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00	
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00	
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00	
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00	
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00	
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)						70.00	
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00	
72.00 Program routine service cost (line 9 x line 71)						72.00	
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00	
74.00 Total Program general inpatient routine service costs (line 72 + line 73)						74.00	
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00	
76.00 Per diem capital-related costs (line 75 ÷ line 2)						76.00	
77.00 Program capital-related costs (line 9 x line 76)						77.00	
78.00 Inpatient routine service cost (line 74 minus line 77)						78.00	
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)						79.00	
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00	
81.00 Inpatient routine service cost per diem limitation						81.00	
82.00 Inpatient routine service cost limitation (line 9 x line 81)						82.00	
83.00 Reasonable inpatient routine service costs (see instructions)						83.00	
84.00 Program inpatient ancillary services (see instructions)						84.00	
85.00 Utilization review - physician compensation (see instructions)						85.00	
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)						86.00	
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)					890	87.00	
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,021.06	88.00	
89.00 Observation bed cost (line 87 x line 88) (see instructions)					908,743	89.00	

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151335		Period: From 07/01/2010 To 06/30/2011		Worksheet D-1 Date/Time Prepared: 1/30/2012 5:43 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Hospital Total Observation Bed Cost (from line 89)	Cost Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 151335	Period: From 07/01/2010 To 06/30/2011	Worksheet D-3 Date/Time Prepared: 1/30/2012 5:43 pm
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Cost Center Description	Title XVIII		Hospital		Cost
	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)		
	1.00	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 ADULTS & PEDIATRICS		1,289,924		30.00	
31.00 INTENSIVE CARE UNIT		913,852		31.00	
42.00 SUBPROVIDER		0		42.00	
43.00 NURSERY				43.00	
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	0.491000	896,433	440,149	50.00	
51.00 RECOVERY ROOM	0.000000	0	0	51.00	
52.00 DELIVERY ROOM & LABOR ROOM	1.318176	5,541	7,304	52.00	
53.00 ANESTHESIOLOGY	0.462354	11,291	5,220	53.00	
54.00 RADIOLOGY-DIAGNOSTIC	0.213932	835,777	178,799	54.00	
57.00 CT SCAN	0.000000	0	0	57.00	
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00	
59.00 CARDIAC CATHETERIZATION	0.475577	604,190	287,339	59.00	
60.00 LABORATORY	0.364917	1,055,657	385,227	60.00	
64.00 INTRAVENOUS THERAPY	0.000000	0	0	64.00	
65.00 RESPIRATORY THERAPY	0.409601	319,237	130,760	65.00	
66.00 PHYSICAL THERAPY	0.508691	43,710	22,235	66.00	
67.00 OCCUPATIONAL THERAPY	0.000000	0	0	67.00	
68.00 SPEECH PATHOLOGY	0.000000	0	0	68.00	
69.00 ELECTROCARDIOLOGY	0.190266	628,090	119,504	69.00	
70.00 ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00	
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00	
72.00 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00	
73.00 DRUGS CHARGED TO PATIENTS	0.431192	1,789,179	771,480	73.00	
74.00 RENAL DIALYSIS	0.000000	0	0	74.00	
76.97 CARDIAC REHABILITATION	0.968775	199	193	76.97	
OUTPATIENT SERVICE COST CENTERS					
91.00 EMERGENCY	0.563947	16,323	9,205	91.00	
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	1.144289	0	0	92.00	
OTHER REIMBURSABLE COST CENTERS					
95.00 AMBULANCE SERVICES				95.00	
200.00 Total (sum of lines 50-94 and 96-98)		6,205,627	2,357,415	200.00	
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00	
202.00 Net Charges (line 200 minus line 201)		6,205,627		202.00	

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 151335	Period: From 07/01/2010 To 06/30/2011	Worksheet D-3 Date/Time Prepared: 1/30/2012 5:43 pm
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Cost Center Description	Title XIX		Hospital		Cost
	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)		
	1.00	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS		115,649		30.00
31.00	INTENSIVE CARE UNIT		83,934		31.00
42.00	SUBPROVIDER		0		42.00
43.00	NURSERY		806		43.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.491000	64,577	31,707	50.00
51.00	RECOVERY ROOM	0.000000	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	1.318176	47,609	62,757	52.00
53.00	ANESTHESIOLOGY	0.462354	1,662	768	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.213932	64,401	13,777	54.00
57.00	CT SCAN	0.000000	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0.809314	140,144	113,421	59.00
60.00	LABORATORY	0.436084	90,763	39,580	60.00
64.00	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	RESPIRATORY THERAPY	0.676151	90,843	61,424	65.00
66.00	PHYSICAL THERAPY	0.508691	1,754	892	66.00
67.00	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	ELECTROCARDIOLOGY	0.190266	34,131	6,494	69.00
70.00	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.431192	188,811	81,414	73.00
74.00	RENAL DIALYSIS	0.000000	0	0	74.00
76.97	CARDIAC REHABILITATION	0.968775	194	188	76.97
OUTPATIENT SERVICE COST CENTERS					
91.00	EMERGENCY	0.563947	41,272	23,275	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.144289	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50-94 and 96-98)		766,161	435,697	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net Charges (line 200 minus line 201)		766,161		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151335	Period: From 07/01/2010 To 06/30/2011	Worksheet E Part B Date/Time Prepared: 1/30/2012 5:43 pm
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			5,895,958 1.00
2.00	Medical and other services reimbursed under OPPIs (see instructions)			0 2.00
3.00	PPS payments			0 3.00
4.00	Outlier payment (see instructions)			0 4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000 5.00
6.00	Line 2 times line 5			0 6.00
7.00	Sum of line 3 plus line 4 divided by line 6			0.00 7.00
8.00	Transitional corridor payment (see instructions)			0 8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200			0 9.00
10.00	Organ acquisitions			0 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			5,895,958 11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges			0 12.00
13.00	Organ acquisition charges (from worksheet D-4, Part III, line 69, col. 4)			0 13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0 14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000 17.00
18.00	Total customary charges (see instructions)			0 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0 19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0 20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)			5,954,918 21.00
22.00	Interns and residents (see instructions)			0 22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)			0 23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)			0 24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)			31,247 25.00
26.00	Deductibles and coinsurance relating to amount on line 24 (for CAH, see instructions)			2,467,241 26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)			3,456,430 27.00
28.00	Direct graduate medical education payments (from worksheet E-4, line 50)			0 28.00
29.00	ESRD direct medical education costs (from worksheet E-4, line 36)			0 29.00
30.00	Subtotal (sum of lines 27 through 29)			3,456,430 30.00
31.00	Primary payer payments			2,071 31.00
32.00	Subtotal (line 30 minus line 31)			3,454,359 32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from worksheet I-5, line 11)			0 33.00
34.00	Allowable bad debts (see instructions)			422,958 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			422,958 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			401,764 36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)			3,877,317 37.00
38.00	MSP-LCC reconciliation amount from PS&R			0 38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0 39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)			3,877,317 40.00
41.00	Interim payments			3,485,837 41.00
42.00	Tentative settlement (for contractors use only)			0 42.00
43.00	Balance due provider/program (line 40 minus the sum of lines 41, and 42)			391,480 43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			0 44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0 90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0 91.00
92.00	The rate used to calculate the Time Value of Money			0.00 92.00
93.00	Time Value of Money (see instructions)			0 93.00
94.00	Total (sum of lines 91 and 93)			0 94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151335	Period: From 07/01/2010 To 06/30/2011	Worksheet E Part B Date/Time Prepared: 1/30/2012 5:43 pm
Title XVIII		Hospital	Cost
WORKSHEET OVERRIDE VALUES			Overrides
112.00 Override of Ancillary service charges (line 12)			1.00
			0 112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CCN: 151335	Period: From 07/01/2010 To 06/30/2011	Worksheet E-1 Part I Date/Time Prepared: 1/30/2012 5:43 pm
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		Title XVIII		Hospital		Cost	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		5,341,470		3,501,001	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM	03/03/2011	109,852	03/03/2011	15,164	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		-109,852		-15,164	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to wkst. E or Wkst. E-3, line and column as appropriate)		5,231,618		3,485,837	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						5.00
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)						6.00
6.01	SETTLEMENT TO PROVIDER		377,167		391,480	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		5,608,785		3,877,317	7.00	
				Contractor Number	Date (Mo/Day/Yr)		
			0	1.00	2.00		
8.00	Name of Contractor						8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151335	Period: From 07/01/2010 To 06/30/2011	Worksheet E-3 Part V Date/Time Prepared: 1/30/2012 5:43 pm
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		Title XVIII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHS)				
1.00	Inpatient services			6,061,861 1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction)			0 2.00
3.00	Organ acquisition			0 3.00
4.00	Subtotal (sum of lines 1 thru 3)			6,061,861 4.00
5.00	Primary payer payments			7,444 5.00
6.00	Total cost (line 4 less line 5) . For CAH (see instructions)			6,115,036 6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
7.00	Routine service charges			0 7.00
8.00	Ancillary service charges			0 8.00
9.00	Organ acquisition charges, net of revenue			0 9.00
10.00	Total reasonable charges			0 10.00
Customary charges				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0 12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.000000 13.00
14.00	Total customary charges (see instructions)			0 14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)			0 15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)			0 16.00
17.00	Cost of teaching physicians (from worksheet D-5, Part II, column 3, line 20) (see instructions)			0 17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from worksheet E-4, line 49)			0 18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)			6,115,036 19.00
20.00	Deductibles (exclude professional component)			596,711 20.00
21.00	Excess reasonable cost (from line 16)			0 21.00
22.00	Subtotal (line 19 minus line 20)			5,518,325 22.00
23.00	Coinsurance			3,850 23.00
24.00	Subtotal (line 22 minus line 23)			5,514,475 24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			94,310 25.00
26.00	Adjusted reimbursable bad debts (see instructions)			94,310 26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			86,546 27.00
28.00	Subtotal (sum of lines 24 and 25 or 26)			5,608,785 28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 29.00
29.99	Recovery of Accelerated Depreciation			0 29.99
30.00	Subtotal (line 28, plus or minus lines 29)			5,608,785 30.00
31.00	Interim payments			5,231,618 31.00
32.00	Tentative settlement (for contractor use only)			0 32.00
33.00	Balance due provider/program (line 30 minus the sum of lines 31, and 32)			377,167 33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2			0 34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151335	Period: From 07/01/2010 To 06/30/2011	Worksheet E-3 Part VII Date/Time Prepared: 1/30/2012 5:43 pm
		Title XIX	Hospital	Cost
				1.00
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		1,297,524	1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)		0	3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		1,297,524	4.00
5.00	Inpatient primary payer payments		0	5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		1,297,524	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges		200,389	8.00
9.00	Ancillary service charges		766,161	9.00
10.00	Organ acquisition charges, net of revenue		0	10.00
11.00	Incentive from target amount computation		0	11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		966,550	12.00
CUSTOMARY CHRGES				
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	15.00
16.00	Total customary charges (see instructions)		966,550	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		330,974	18.00
19.00	Interns and Residents (see instructions)		0	19.00
20.00	Cost of Teaching Physicians (see instructions)		0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		966,550	21.00
PROSPECTIVE PAYMENT AMOUNT				
22.00	Other than outlier payments		0	22.00
23.00	Outlier payments		0	23.00
24.00	Program capital payments		0	24.00
25.00	Capital exception payments (see instructions)		0	25.00
26.00	Routine and Ancillary service other pass through costs		0	26.00
27.00	Subtotal (sum of lines 22 through 26, plus line 3 minus lines 5 and 6)		0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	28.00
29.00	Titles V or XIX enter the sum of lines 27 and 21.		966,550	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		330,974	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		966,550	31.00
32.00	Deductibles		0	32.00
33.00	Coinsurance		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Utilization review		0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		966,550	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	37.00
38.00	Subtotal (line 36 ± line 37)		966,550	38.00
39.00	Direct graduate medical education payments (from wkst. E-4)		0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		966,550	40.00
41.00	Interim payments		966,550	41.00
42.00	Balance due provider/program (line 40 minus 41)		0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2		0	43.00

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

Provider CCN: 151335

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

Worksheet G

Date/Time Prepared:
1/30/2012 5:43 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	2,233,284	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	9,468,214	0	0	0	4.00
5.00	Other receivable	1,452,217	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-6,294,109	0	0	0	6.00
7.00	Inventory	865,096	0	0	0	7.00
8.00	Prepaid expenses	74,593	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	7,799,295	0	0	0	11.00
FIXED ASSETS						
12.00	Land	100,000	0	0	0	12.00
13.00	Land improvements	60,000	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	9,121,880	0	0	0	15.00
16.00	Accumulated depreciation	-1,390,358	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	7,891,522	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	31,821	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	31,821	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	15,690,817	31,821	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	486,650	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,317,499	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	57,088	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	6,924,146	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	8,785,383	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	7,878,364	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	7,878,364	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	16,663,747	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	-972,930				52.00
53.00	Specific purpose fund		31,821			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	-972,930	31,821	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	15,690,817	31,821	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151335

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

Worksheet G-1

Date/Time Prepared:
1/30/2012 5:43 pm

	General Fund		Special Purpose Fund		
	1.00	2.00	3.00	4.00	
	1.00		0		
2.00		-972,930			2.00
3.00		-972,930		0	3.00
4.00	0		0		4.00
5.00	0		0		5.00
6.00	0		0		6.00
7.00	0		0		7.00
8.00	0		0		8.00
9.00	0		0		9.00
10.00		0		0	10.00
11.00		-972,930		0	11.00
12.00	0		0		12.00
13.00	0		0		13.00
14.00	0		0		14.00
15.00	0		0		15.00
16.00	0		0		16.00
17.00	0		0		17.00
18.00		0		0	18.00
19.00		-972,930		0	19.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151335

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

Worksheet G-1

Date/Time Prepared:
1/30/2012 5:43 pm

	Endowment Fund		Plant Fund			
	5.00	6.00	7.00	8.00		
1.00 Fund balances at beginning of period		0		0		1.00
2.00 Net income (loss) (from wkst. G-3, line 29)						2.00
3.00 Total (sum of line 1 and line 2)		0		0		3.00
4.00 Additions (credit adjustments) (specify)	0		0			4.00
5.00	0		0			5.00
6.00	0		0			6.00
7.00	0		0			7.00
8.00	0		0			8.00
9.00	0		0			9.00
10.00 Total additions (sum of line 4-9)		0		0		10.00
11.00 Subtotal (line 3 plus line 10)		0		0		11.00
12.00 Deductions (debit adjustments) (specify)	0		0			12.00
13.00	0		0			13.00
14.00	0		0			14.00
15.00	0		0			15.00
16.00	0		0			16.00
17.00	0		0			17.00
18.00 Total deductions (sum of lines 12-17)		0		0		18.00
19.00 Fund balance at end of period per balance sheet (line 11 minus line 18)		0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 151335

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

Worksheet G-2 Parts

Date/Time Prepared:
1/30/2012 5:43 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	4,371,350		4,371,350	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER	0		0	4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	0		0	7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	4,371,350		4,371,350	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	1,483,579		1,483,579	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	1,483,579		1,483,579	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	5,854,929		5,854,929	17.00
18.00	Ancillary services	12,214,965	41,189,689	53,404,654	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		0	0	22.00
23.00	AMBULANCE SERVICES	0	594,859	594,859	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN REVENUE	0	558,242	558,242	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to wkst. G-3, line 1)	18,069,894	42,342,790	60,412,684	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per wkst. A, column 3, line 200)		28,522,625		29.00
30.00	BAD DEBTS	2,204,057			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		2,204,057		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to wkst. G-3, line 4)		30,726,682		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 151335	Period: From 07/01/2010 To 06/30/2011	Worksheet G-3 Date/Time Prepared: 1/30/2012 5:43 pm
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		1.00	
1.00	Total patient revenues (from wkst. G-2, Part I, column 3, line 28)	60,412,684	1.00
2.00	Less contractual allowances and discounts on patients' accounts	31,394,929	2.00
3.00	Net patient revenues (line 1 minus line 2)	29,017,755	3.00
4.00	Less total operating expenses (from wkst. G-2, Part II, line 43)	30,726,682	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,708,927	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	19,576	7.00
8.00	Revenues from telephone and telegraph service	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	110,230	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	21,367	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	63,885	22.00
23.00	Governmental appropriations	384,218	23.00
24.00	GAIN ON SALE	50,000	24.00
24.01	MISC	91,677	24.01
24.02	MISC DIETARY	2,346	24.02
24.03	MISC A&G	20	24.03
24.04		0	24.04
24.05		0	24.05
25.00	Total other income (sum of lines 6-24)	743,319	25.00
26.00	Total (line 5 plus line 25)	-965,608	26.00
27.00	UNREALIZED LOSS	7,322	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	7,322	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-972,930	29.00

St. Vincent Dunn
Bed Changes
7/1/10 - 6/30/11

	Beginning	Change 11/1/10	Ending
Routine	18	3	21
ICU	7	(3)	4
	<u>25</u>	<u>-</u>	<u>25</u>