

**ST. VINCENT FRANKFORT HOSPITAL  
FRANKFORT, INDIANA**

**PROVIDER NOS. 15-1316, 15-Z316 and AIM NO. 100268560A**

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

**June 30, 2011**

ST. VINCENT FRANKFORT HOSPITAL

PROVIDER NOS. 15-1316, 15-Z316 and AIM NO. 100268560A

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Accountants' Disclaimer

Hospital Statements of Reimbursable Costs



Board of Directors  
St. Vincent Frankfort Hospital  
Frankfort, Indiana

We have compiled the Hospital Statements of Reimbursable Costs (Titles XVIII and XIX) of St. Vincent Frankfort Hospital (Provider Nos. 15-1316, 15-Z316 and AIM NO. 100268560A) for the year ended June 30, 2011 in the accompanying prescribed form in accordance with Statements on Standards for Accounting Review Services issued by the American Institute of Certified Public Accountants.

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

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

This 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: 151316  
 Period: From 07/01/2010 To 06/30/2011  
 worksheet 5 Parts I-III  
 Date/Time Prepared: 1/27/2012 3:43 pm

**PART I - COST REPORT STATUS**

Provider use only  
 1.  Electronically filed cost report  
 2.  Manually submitted cost report  
 3.  If this is an amended report enter the number of times the provider resubmitted this cost report  
 4.  Medicare Utilization. Enter "F" for full or "L" for low.  
 Date: 1/27/2012 Time: 3:43 pm

Contractor use only  
 5.  Cost Report Status  
 (1) As Submitted  
 (2) Settled without Audit  
 (3) Settled with Audit  
 (4) Reopened  
 (5) Amended  
 6. Date Received:  
 7. Contractor No.  
 8.  Initial Report for this Provider CCN  
 9.  Final Report for this Provider CCN  
 10. NPR Date:  
 11. Contractor's Vendor Code: 4  
 12.  If line 5, column 1 is 4: Enter number of times reopened = 0-9.

**PART II - CERTIFICATION**

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST. VINCENT FRANKFORT 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: 1/27/2012 Time: 3:43 pm  
 jmrhLwvYcTJEPnEY.GB1N7kCIBPe90  
 v.NkG00LS:uzp0zem9XkMvqv23fcqF  
 yyew0pm7x60D04sz  
 PI: Date: 1/27/2012 Time: 3:43 pm  
 G9Fui5DAcfuU6ukv4T6dFf:x9.9cs0  
 RR.lS0poQXyucG.l78f4cvPisDmg6l  
 dimVOLFwNbn0.ydB.

(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			
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	470,294	227,948	0	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
4.00 SUBPROVIDER I	0	0	0		0	4.00
5.00 Swing bed - SNF	0	129,413	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
7.00 Skilled Nursing Facility	0	0	0		0	7.00
8.00 Nursing Facility	0				0	8.00
9.00 HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00 RURAL HEALTH CLINIC I	0				0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0				0	11.00
12.00 CMHC I	0				0	12.00
200.00 Total	0	599,707	227,948	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: 151316      Period: From 07/01/2010 To 06/30/2011      worksheet S-2 Part I Date/Time Prepared: 1/26/2012 9:13 am

		1.00	2.00	3.00	4.00						
<b>Hospital and Hospital Health Care Complex Address:</b>											
1.00	Street: 1300 SOUTH JACKSON STREET	PO Box:		Zip Code: 46041		County: CLINTON				1.00	
2.00	City: FRANKFORT	State: IN								2.00	
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
							V	XVIII	XIX		
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00		
<b>Hospital and Hospital-Based Component Identification:</b>											
3.00	Hospital	ST. VINCENT FRANKFORT HOSPITAL	151316	15	1	01/21/2003	N	O	O	3.00	
4.00	Subprovider - IPF									4.00	
5.00	Subprovider - IRF									5.00	
6.00	Subprovider - (Other)									6.00	
7.00	Swing Beds - SNF	ST. VINCENT FRANKFORT HOSPITAL	152316	15		01/21/2003	N	O	N	7.00	
8.00	Swing Beds - NF						N		N	8.00	
9.00	Hospital-Based SNF									9.00	
10.00	Hospital-Based NF									10.00	
11.00	Hospital-Based OLTC									11.00	
12.00	Hospital-Based HHA									12.00	
13.00	Separately Certified ASC									13.00	
14.00	Hospital-Based Hospice									14.00	
15.00	Hospital-Based Health Clinic - RHC									15.00	
16.00	Hospital-Based Health Clinic - FQHC									16.00	
17.00	Hospital-Based (CMHC) 1						N	N	N	17.00	
17.10	Hospital-Based (CORF) 1						N	N	N	17.10	
18.00	Renal Dialysis									18.00	
19.00	Other									19.00	
						From:	To:				
						1.00	2.00				
20.00	Cost Reporting Period (mm/dd/yyyy)					07/01/2010	06/30/2011		20.00		
21.00	Type of Control (see instructions)					2			21.00		
<b>Inpatient PPS Information</b>											
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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151316	Period: From 07/01/2010 To 06/30/2011	Worksheet S-2 Part I Date/Time Prepared: 1/26/2012 9:13 am		
		Beginning: 1.00	Ending: 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
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.					38.00
		V 1.00	XVIII 2.00	XIX 3.00		
<b>Prospective Payment System (PPS)-Capital</b>						
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
<b>Teaching Hospitals</b>						
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.	N				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
<b>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</b>						
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
<b>Teaching Hospitals that Claim Residents in Non-Provider Settings</b>						
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 151316

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

Worksheet S-2  
Part 1  
Date/Time Prepared:  
1/26/2012 9:13 am

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
		1.00	2.00	3.00	4.00	5.00		
65.00	Enter in column 1 the program name. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00	
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
				1.00	2.00	3.00		
66.00	<b>Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010</b> Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	66.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
		1.00	2.00	3.00	4.00	5.00		
67.00	Enter in column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00	
						1.00	2.00	3.00
70.00	<b>Inpatient Psychiatric Facility PPS</b> Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.					N		70.00
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)						0	71.00
75.00	<b>Inpatient Rehabilitation Facility PPS</b> Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.					N		75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)						0	76.00
						1.00		
80.00	<b>Long Term Care Hospital PPS</b> Is this a Long Term Care Hospital (LTCH)? Enter "Y" for yes or "N" for no.						N	80.00

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151316	Period: From 07/01/2010 To 06/30/2011	Worksheet S-2 Part I Date/Time Prepared: 1/26/2012 9:13 am	
					1.00
<b>TEFRA Providers</b>					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			N	86.00
					V 1.00
					XIX 2.00
<b>Title V or XIX Inpatient Services</b>					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.		N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.		N	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.		N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.		N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.		N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	97.00
<b>Rural Providers</b>					
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?		Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)		N		106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)		N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		N		108.00
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	Y	Y	N	N
					1.00
					2.00
<b>Miscellaneous Cost Reporting Information</b>					
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	120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.		N		121.00
<b>Transplant Center Information</b>					
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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151316	Period: From 07/01/2010 To 06/30/2011	Worksheet S-2 Part I Date/Time Prepared: 1/26/2012 9:13 am		
			1.00		2.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00
<b>All Providers</b>						
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)					140.00
			1.00		2.00	
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.						
141.00	Name: ST. VINCENT HEALTH	Contractor's Name: NATIONAL GOVERNMENT SERVICES	Contractor's Number: 15H046			141.00
142.00	Street: 10330 N. MERIDIAN ST. SUITE 420	PO Box:				142.00
143.00	City: INDIANAPOLIS	State:	Zip Code:	46290		143.00
			1.00			
144.00	Are provider based physicians' costs included in worksheet A?					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.					145.00
			1.00		2.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.					146.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.					147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.					148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.					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			
<b>Multicampus</b>						
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.					165.00
		Name	County	State	Zip Code	CBSA
		0	1.00	2.00	3.00	4.00
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
						5.00
						166.00
			1.00			
<b>Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act</b>						
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.					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)					168.00
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: 151316	Period: From 07/01/2010 To 06/30/2011	Worksheet S-2 Part II Date/Time Prepared: 1/26/2012 9:13 am
			Y/N 1.00	Date 2.00
<b>General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.</b>				
<b>COMPLETED BY ALL HOSPITALS</b>				
<b>Provider Organization and Operation</b>				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
			Y/N 1.00	Date 2.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N		3.00
			Y/N 1.00	Type 2.00
				Date 3.00
<b>Financial Data and Reports</b>				
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
<b>Approved Educational Activities</b>				
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.			11.00
			Y/N 1.00	
<b>Bad Debts</b>				
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
<b>Bed Complement</b>				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N	15.00
			<b>Part A</b>	
			Y/N 1.00	Date 2.00
<b>PS&amp;R Data</b>				
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

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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.	N	2.00	21.00
				1.00
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>				
<b>Capital Related Cost</b>				
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
<b>Interest Expense</b>				
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
<b>Purchased Services</b>				
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
<b>Provider-Based Physicians</b>				
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	
<b>Home Office Costs</b>				
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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 151316

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

Worksheet S-2  
Part II  
Date/Time Prepared:  
1/26/2012 9:13 am

		Part B		
		Y/N	Date	
		3.00	4.00	
<b>PS&amp;R Data</b>				
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.			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.			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:			20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		21.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151316

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
1/26/2012 9:13 am

Cost Center Description	Worksheet A	No. of Beds	Bed Days Available	CAH Hours		
	Line Number					
	1.00	2.00	3.00	4.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	25	9,125	72,984.00		1.00
2.00 HMO						2.00
3.00 HMO IPF						3.00
4.00 HMO IRF						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	72,984.00		7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00					13.00
14.00 Total (see instructions)		25	9,125	72,984.00		14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
25.00 CMHC - CMHC	99.00					25.00
25.10 CMHC - CORF	99.10					25.10
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		25				27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151316

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
1/26/2012 9:13 am

Cost Center Description	I/P Days / O/P Visits / Trips				Total All Patients	
	Title V	Title XVIII	Title XIX			
	5.00	6.00	7.00	8.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	0	1,916	466	3,054	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	759	0	759	5.00	
6.00 Hospital Adults & Peds. Swing Bed NF	0		0	134	6.00	
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	0	2,675	466	3,947	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	0		184	423	13.00	
14.00 Total (see instructions)	0	2,675	650	4,370	14.00	
15.00 CAH visits	0	0	0	0	15.00	
16.00 SUBPROVIDER - IPF					16.00	
17.00 SUBPROVIDER - IRF					17.00	
18.00 SUBPROVIDER					18.00	
19.00 SKILLED NURSING FACILITY					19.00	
20.00 NURSING FACILITY					20.00	
21.00 OTHER LONG TERM CARE					21.00	
22.00 HOME HEALTH AGENCY					22.00	
23.00 AMBULATORY SURGICAL CENTER (D.P.)					23.00	
24.00 HOSPICE					24.00	
25.00 CMHC - CMHC	0	0	0	0	25.00	
25.10 CMHC - CORF	0	0	0	0	25.10	
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	569	28.00	
29.00 Ambulance Trips		0			29.00	
30.00 Employee discount days (see instruction)				44	30.00	
31.00 Employee discount days - IRF				0	31.00	
32.00 Labor & delivery days (see instructions)			0	0	32.00	
33.00 LTCH non-covered days		0			33.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151316

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
1/26/2012 9:13 am

Cost Center Description	Full Time Equivalents			Discharges		
	Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	9.00	10.00	11.00	12.00	13.00	1.00
2.00 HMO				0	474	2.00
3.00 HMO IPF					0	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	153.11	0.00	0	474	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
25.00 CMHC - CMHC	0.00	0.00	0.00			25.00
25.10 CMHC - CORF	0.00	0.00	0.00			25.10
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	153.11	0.00			27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151316

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
1/26/2012 9:13 am

Cost Center Description	Discharges			
	Title XIX	Total All Patients		
	14.00	15.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	188	903		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)	188	903		14.00
15.00 CAH visits				15.00
16.00 SUBPROVIDER - IPF				16.00
17.00 SUBPROVIDER - IRF				17.00
18.00 SUBPROVIDER				18.00
19.00 SKILLED NURSING FACILITY				19.00
20.00 NURSING FACILITY				20.00
21.00 OTHER LONG TERM CARE				21.00
22.00 HOME HEALTH AGENCY				22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)				23.00
24.00 HOSPICE				24.00
25.00 CMHC - CMHC				25.00
25.10 CMHC - CORF				25.10
26.00 RURAL HEALTH CLINIC				26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER				26.25
27.00 Total (sum of lines 14-26)				27.00
28.00 Observation Bed Days				28.00
29.00 Ambulance Trips				29.00
30.00 Employee discount days (see instruction)				30.00
31.00 Employee discount days - IRF				31.00
32.00 Labor & delivery days (see instructions)				32.00
33.00 LTCH non-covered days				33.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 151316	Period: From 07/01/2010 To 06/30/2011	Worksheet S-10	Date/Time Prepared: 1/26/2012 9:13 am
					1.00
<b>Uncompensated and indigent care cost computation</b>					
1.00	Cost to charge ratio (Worksheet C, Part I line 200 column 3 divided by line 200 column 8)		0.327054		1.00
<b>Medicaid (see instructions for each line)</b>					
2.00	Net revenue from Medicaid		3,953,675		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y		3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		N		4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		1,449,778		5.00
6.00	Medicaid charges		10,922,311		6.00
7.00	Medicaid cost (line 1 times line 6)		3,572,186		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)		0		8.00
<b>State Children's Health Insurance Program (SCHIP) (see instructions for each line)</b>					
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
<b>Other state or local government indigent care program (see instructions for each line)</b>					
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
<b>Uncompensated care (see instructions for each line)</b>					
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		10,928		18.00
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		0		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	0	0	0	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	0	0	0	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)	0	0	0	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?				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)			0	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)			621,688	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)			-621,688	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)			-203,326	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)			-203,326	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			-203,326	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES			Provider CCN: 151316	Period: From 07/01/2010 To 06/30/2011	worksheet A Date/Time Prepared: 1/26/2012 9:13 am		
Cost-Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)		
	1.00	2.00	3.00	4.00	5.00		
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	NEW CAP REL COSTS-BLDG & FIXT		1,097,341	1,097,341	0	1,097,341	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP		778,175	778,175	-5,253	772,922	2.00
3.00	OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00	EMPLOYEE BENEFITS	206,034	2,892,754	3,098,788	0	3,098,788	4.00
5.00	ADMINISTRATIVE & GENERAL	1,567,241	2,278,273	3,845,514	5,253	3,850,767	5.00
6.00	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	OPERATION OF PLANT	232,505	1,227,718	1,460,223	0	1,460,223	7.00
7.01	UTILITIES	0	0	0	0	0	7.01
8.00	LAUNDRY & LINEN SERVICE	0	111,679	111,679	0	111,679	8.00
9.00	HOUSEKEEPING	270,778	125,665	396,443	0	396,443	9.00
10.00	DIETARY	246,063	267,291	513,354	-174,483	338,871	10.00
11.00	CAFETERIA	0	0	0	174,483	174,483	11.00
12.00	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	NURSING ADMINISTRATION	819,921	49,708	869,629	0	869,629	13.00
14.00	CENTRAL SERVICES & SUPPLY	141,242	-17,863	123,379	0	123,379	14.00
15.00	PHARMACY	248,435	728,904	977,339	0	977,339	15.00
16.00	MEDICAL RECORDS & LIBRARY	0	47,043	47,043	0	47,043	16.00
17.00	SOCIAL SERVICE	0	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	ADULTS & PEDIATRICS	1,849,884	204,775	2,054,659	-438,924	1,615,735	30.00
43.00	NURSERY	0	0	0	106,807	106,807	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM	463,584	687,450	1,151,034	0	1,151,034	50.00
51.00	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	332,117	332,117	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	635,702	315,312	951,014	0	951,014	54.00
55.00	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	RADIOISOTOPE	0	0	0	0	0	56.00
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	668,062	810,285	1,478,347	0	1,478,347	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
61.00	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	169,304	143,826	313,130	0	313,130	65.00
66.00	PHYSICAL THERAPY	920	751,193	752,113	0	752,113	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	53,376	580	53,956	0	53,956	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
71.30	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	71.30
72.00	IMPL. DEV. CHARGED TO PATIENT	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
75.00	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	EMERGENCY	858,042	829,059	1,687,101	0	1,687,101	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.00	CMHC	0	0	0	0	0	99.00
99.10	CORF	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00	SUBTOTALS (SUM OF LINES 1-117)	8,431,093	13,329,168	21,760,261	0	21,760,261	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	RESEARCH	0	0	0	0	0	191.00
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	OTHER NONREIMBURSABLE - CLINIC	91,987	22,122	114,109	0	114,109	194.00
194.01	OTHER NONREIMBURSABLE - FOUNDATION	6,677	13,503	20,180	0	20,180	194.01
194.02	OTHER NONREIMBURSABLE - MARKETING	0	17	17	0	17	194.02
200.00	TOTAL (SUM OF LINES 118-199)	8,529,757	13,364,810	21,894,567	0	21,894,567	200.00

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RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151316

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

worksheet A

Date/Time Prepared:  
1/26/2012 9:13 am

Cost Center Description		Adjustments (See A-8) 6.00	Net Expenses For Allocation 7.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	NEW CAP REL COSTS-BLDG & FIXT	-3,323	1,094,018	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	421,896	1,194,818	2.00
3.00	OTHER CAPITAL RELATED COSTS	0	0	3.00
4.00	EMPLOYEE BENEFITS	315,139	3,413,927	4.00
5.00	ADMINISTRATIVE & GENERAL	-96,643	3,754,124	5.00
6.00	MAINTENANCE & REPAIRS	0	0	6.00
7.00	OPERATION OF PLANT	0	1,460,223	7.00
7.01	UTILITIES	0	0	7.01
8.00	LAUNDRY & LINEN SERVICE	0	111,679	8.00
9.00	HOUSEKEEPING	-450	395,993	9.00
10.00	DIETARY	-149,052	189,819	10.00
11.00	CAFETERIA	0	174,483	11.00
12.00	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	NURSING ADMINISTRATION	-2,592	867,037	13.00
14.00	CENTRAL SERVICES & SUPPLY	-104	123,275	14.00
15.00	PHARMACY	-16,919	960,420	15.00
16.00	MEDICAL RECORDS & LIBRARY	-7,581	39,462	16.00
17.00	SOCIAL SERVICE	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	ADULTS & PEDIATRICS	0	1,615,735	30.00
43.00	NURSERY	0	106,807	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	OPERATING ROOM	-2,344	1,148,690	50.00
51.00	RECOVERY ROOM	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	332,117	52.00
53.00	ANESTHESIOLOGY	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	951,014	54.00
55.00	RADIOLOGY-THERAPEUTIC	0	0	55.00
56.00	RADIOISOTOPE	0	0	56.00
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	1,478,347	60.00
60.01	BLOOD LABORATORY	0	0	60.01
61.00	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
64.00	INTRAVENOUS THERAPY	0	0	64.00
65.00	RESPIRATORY THERAPY	-20,892	292,238	65.00
66.00	PHYSICAL THERAPY	-26,038	726,075	66.00
67.00	OCCUPATIONAL THERAPY	0	0	67.00
68.00	SPEECH PATHOLOGY	0	53,956	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
71.30	IMPL. DEV. CHARGED TO PATIENT	0	0	71.30
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	RENAL DIALYSIS	0	0	74.00
75.00	ASC (NON-DISTINCT PART)	0	0	75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
91.00	EMERGENCY	-84,947	1,602,154	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
99.00	CMHC	0	0	99.00
99.10	CORF	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>				
118.00	SUBTOTALS (SUM OF LINES 1-117)	326,150	22,086,411	118.00
<b>NONREIMBURSABLE COST CENTERS</b>				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
191.00	RESEARCH	0	0	191.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
193.00	NONPAID WORKERS	0	0	193.00
194.00	OTHER NONREIMBURSABLE - CLINIC	0	114,109	194.00
194.01	OTHER NONREIMBURSABLE - FOUNDATION	0	20,180	194.01
194.02	OTHER NONREIMBURSABLE - MARKETING	281,072	281,089	194.02
200.00	TOTAL (SUM OF LINES 118-199)	607,222	22,501,789	200.00

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Increases					
Cost Center	Line #	Salary	Other		
2.00	3.00	4.00	5.00		
<b>A - DIET TO CAFE</b>					
1.00	CAFETERIA	11.00	83,634	90,849	1.00
	TOTALS		83,634	90,849	
<b>B - OB RELCASS</b>					
1.00	NURSERY	43.00	94,679	12,128	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	294,404	37,713	2.00
	TOTALS		389,083	49,841	
<b>C - ADMIN AND GENERAL</b>					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	5,253	1.00
	TOTALS		0	5,253	
500.00	Grand Total: Increases		472,717	145,943	500.00

Decreases						wkst. A-7 Ref.	
Cost Center	Line #	Salary	Other				
6.00	7.00	8.00	9.00	10.00			
<b>A - DIET TO CAFE</b>							
1.00	DIETARY	10.00	83,634	90,849	0		1.00
	TOTALS		83,634	90,849			
<b>B - OB RELCASS</b>							
1.00	ADULTS & PEDIATRICS	30.00	389,083	49,841	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		389,083	49,841			
<b>C - ADMIN AND GENERAL</b>							
1.00	NEW CAP REL COSTS-MVBLE	2.00	0	5,253	9		1.00
	EQUIP						
	TOTALS		0	5,253			
500.00	Grand Total: Decreases		472,717	145,943			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151316

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

Worksheet A-7  
Parts I-III  
Date/Time Prepared:  
1/26/2012 9:13 am

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	140,146	0	0	0	1.00
2.00	Land Improvements	66,241	0	0	0	2.00
3.00	Buildings and Fixtures	1,118,143	0	0	0	3.00
4.00	Building Improvements	603,153	0	0	0	4.00
5.00	Fixed Equipment	642,249	76,352	0	76,352	5.00
6.00	Movable Equipment	5,469,724	41,694	0	41,694	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	8,039,656	118,046	0	118,046	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	8,039,656	118,046	0	118,046	10.00
<b>SUMMARY OF CAPITAL</b>						
Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
	9.00	10.00	11.00	12.00	13.00	
<b>PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2</b>						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,097,341	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	778,175	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,875,516	0	0	0	3.00
<b>COMPUTATION OF RATIOS</b>						
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	
<b>PART III - RECONCILIATION OF CAPITAL COSTS CENTERS</b>						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,927,683	0	1,927,683	0.237219	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	6,198,477	0	6,198,477	0.762781	2.00
3.00	Total (sum of lines 1-2)	8,126,160	0	8,126,160	1.000000	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151316

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

Worksheet A-7  
Parts I-III  
Date/Time Prepared:  
1/26/2012 9:13 am

		Ending Balance	Fully Depreciated Assets			
		6.00	7.00			
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	140,146	0		1.00	
2.00	Land Improvements	66,241	0		2.00	
3.00	Buildings and Fixtures	1,118,143	0		3.00	
4.00	Building Improvements	603,153	0		4.00	
5.00	Fixed Equipment	718,601	0		5.00	
6.00	Movable Equipment	5,502,081	0		6.00	
7.00	HIT designated Assets	0	0		7.00	
8.00	Subtotal (sum of lines 1-7)	8,148,365	0		8.00	
9.00	Reconciling Items	0	0		9.00	
10.00	Total (line 8 minus line 9)	8,148,365	0		10.00	
<b>SUMMARY OF CAPITAL</b>						
Cost Center Description		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)			
		14.00	15.00			
<b>PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2</b>						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	1,097,341		1.00	
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	778,175		2.00	
3.00	Total (sum of lines 1-2)	0	1,875,516		3.00	
<b>ALLOCATION OF OTHER CAPITAL</b>						
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
<b>PART III - RECONCILIATION OF CAPITAL COSTS CENTERS</b>						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1,094,018	0
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	1,194,818	0
3.00	Total (sum of lines 1-2)	0	0	0	2,288,836	0

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151316

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

Worksheet A-7  
Parts I-III  
Date/Time Prepared:  
1/26/2012 9:13 am

Cost Center Description	SUMMARY OF CAPITAL						
	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)		
	11.00	12.00	13.00	14.00	15.00		
<b>PART III - RECONCILIATION OF CAPITAL COSTS CENTERS</b>							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	1,094,018	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	1,194,818	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	2,288,836	3.00

Line #	Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted	
				Cost Center	Line #
				1:00	2:00
1.00	Investment income - buildings and fixtures (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00 1.00
2.00	Investment income - movable equipment (chapter 2)	A	-4,765	NEW CAP REL COSTS-MVBLE EQUIP	2.00 2.00
3.00	Investment income - other (chapter 2)	A	-1,763	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	-3,219	ADMINISTRATIVE & GENERAL	5.00 7.00
8.00	Television and radio service (chapter 21)	A	-2,281	ADMINISTRATIVE & GENERAL	5.00 8.00
9.00	Parking lot (chapter 21)		0		0.00 9.00
10.00	Provider-based physician adjustment	A-8-2	-108,183		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	754,470		12.00 12.00
13.00	Laundry and linen service		0		0.00 13.00
14.00	Cafeteria-employees and guests	B	-149,052	DIETARY	10.00 14.00
15.00	Rental of quarters to employee and others		0		0.00 15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00 16.00
17.00	Sale of drugs to other than patients	B	-16,919	PHARMACY	15.00 17.00
18.00	Sale of medical records and abstracts	B	-7,581	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	NEW CAP REL COSTS-BLDG & FIXT	1.00 26.00
27.00	Depreciation - movable equipment		0	NEW 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	MISC	B	-15,166	ADMINISTRATIVE & GENERAL	5.00 33.00
34.00	MISC	B	-2,592	NURSING ADMINISTRATION	13.00 34.00
35.00	MISC	B	-104	CENTRAL SERVICES & SUPPLY	14.00 35.00
36.00	DONATIONS	A	-11,717	ADMINISTRATIVE & GENERAL	5.00 36.00
37.00	CSI SERVICING FEES	A	32,049	ADMINISTRATIVE & GENERAL	5.00 37.00
38.00	ATHLETIC TRAINER	A	-26,038	PHYSICAL THERAPY	66.00 38.00
41.00	LOBBYING	A	-997	ADMINISTRATIVE & GENERAL	5.00 41.00
42.00	ADMIN OTHER OPERATING INCOME	B	-104	ADMINISTRATIVE & GENERAL	5.00 42.00
45.00	HOUSEKEEPING OTHER OPERATING INCOME	B	-450	HOUSEKEEPING	9.00 45.00
45.01	MARKETING	A	-600	ADMINISTRATIVE & GENERAL	5.00 45.01
45.02	EXCESS RENT EXPENSE	A	200,000	NEW CAP REL COSTS-MVBLE EQUIP	2.00 45.02
45.03	OTHER NON-ALLOWABLE	A	-443	ADMINISTRATIVE & GENERAL	5.00 45.03
45.04	LOSS ON FIXED ASSETS	A	-3,323	NEW CAP REL COSTS-BLDG & FIXT	1.00 45.04
45.05	PAYROLL INCENTIVE	A	-24,000	ADMINISTRATIVE & GENERAL	5.00 45.05
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200.)		607,222		50.00 50.00

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ADJUSTMENTS TO EXPENSES

Provider CCN: 151316

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

worksheet A-8

Date/Time Prepared:  
1/26/2012 9:13 am

		Wkst. A-7 Ref.	
		5.00	
1.00	Investment income - buildings and fixtures (chapter 2)	0	1.00
2.00	Investment income - movable equipment (chapter 2)	9	2.00
3.00	Investment income - other (chapter 2)	9	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	MISC	0	33.00
34.00	MISC	0	34.00
35.00	MISC	0	35.00
36.00	DONATIONS	0	36.00
37.00	CSI SERVICING FEES	0	37.00
38.00	ATHLETIC TRAINER	0	38.00
41.00	LOBBYING	0	41.00
42.00	ADMIN OTHER OPERATING INCOME	0	42.00
45.00	HOUSEKEEPING OTHER OPERATING INCOME	0	45.00
45.01	MARKETING	0	45.01
45.02	EXCESS RENT EXPENSE	9	45.02
45.03	OTHER NON-ALLOWABLE	0	45.03
45.04	LOSS ON FIXED ASSETS	9	45.04
45.05	PAYROLL INCENTIVE	0	45.05
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200.)		50.00

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

Provider CCN: 151316

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

Worksheet A-8-1

Date/Time Prepared:  
1/26/2012 9:13 am

	Line No.		Cost Center		Expense Items		
	1.00		2.00		3.00		
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>							
1.00		2.00	NEW CAP REL COSTS-MVBLE EQUIP		HOME OFFICE	1.00	
2.00		5.00	ADMINISTRATIVE & GENERAL		HOME OFFICE	2.00	
3.00		4.00	EMPLOYEE BENEFITS		HOME OFFICE	3.00	
4.00		2.00	NEW CAP REL COSTS-MVBLE EQUIP		ASCENSION - INTEREST	4.00	
4.01		5.00	ADMINISTRATIVE & GENERAL		ASCENSION - INTEREST	4.01	
4.04		5.00	ADMINISTRATIVE & GENERAL		ASCENSION - MAINTANENCE	4.04	
4.06		4.00	EMPLOYEE BENEFITS		PENSION	4.06	
4.07		4.00	EMPLOYEE BENEFITS		SELF INSURANCE	4.07	
4.08		194.00	OTHER NONREIMBURSABLE - CLINIC		ST. VINCENT HEALTH CHARGE	4.08	
4.09		65.00	RESPIRATORY THERAPY		ST. VINCENT HEALTH CHARGE	4.09	
4.10		54.00	RADIOLOGY-DIAGNOSTIC		ST. VINCENT HEALTH CHARGE	4.10	
4.12		16.00	MEDICAL RECORDS & LIBRARY		ST. VINCENT HEALTH CHARGE	4.12	
4.15		14.00	CENTRAL SERVICES & SUPPLY		ST. VINCENT HEALTH CHARGE	4.15	
4.16		9.00	HOUSEKEEPING		ST. VINCENT HEALTH CHARGE	4.16	
4.17		5.00	ADMINISTRATIVE & GENERAL		ST. VINCENT HEALTH CHARGE	4.17	
4.18		4.00	EMPLOYEE BENEFITS		ST. VINCENT HEALTH CHARGE	4.18	
4.19		194.02	OTHER NONREIMBURSABLE - MARKETING		HOME OFFICE	4.19	
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		0.00	6.00	
7.00		G	ST. VINCENT		0.00	7.00	
8.00					0.00	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.

	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	
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>					
1.00	236,094	0	236,094	9	1.00
2.00	1,670,205	1,708,970	-38,765	0	2.00
3.00	0	99,830	-99,830	0	3.00
4.00	4,765	14,198	-9,433	9	4.00
4.01	1,763	5,253	-3,490	0	4.01
4.04	349,529	375,676	-26,147	0	4.04
4.06	743,640	743,640	0	0	4.06
4.07	1,437,445	1,022,476	414,969	0	4.07
4.08	-2,600	-2,600	0	0	4.08
4.09	100,145	100,145	0	0	4.09
4.10	31,649	31,649	0	0	4.10
4.12	14,801	14,801	0	0	4.12
4.15	13,380	13,380	0	0	4.15
4.16	-46,512	-46,512	0	0	4.16
4.17	662,906	662,906	0	0	4.17
4.18	141,373	141,373	0	0	4.18
4.19	281,072	0	281,072	0	4.19
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to worksheet A-8, column 2, line 12.	5,639,655	4,885,185	754,470	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>B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:</b>		

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 HEALTH	0.00	HOSPITAL MGMT.	6.00
7.00	ASCENSION	0.00	HOSPITAL MGMT.	7.00
8.00		0.00		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.

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151316

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

Worksheet A-8-2

Date/Time Prepared:  
1/26/2012 9:13 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
	1.00	2.00	3.00	4.00	
1.00	91.00	EMERGENCY	592,115	84,947	1.00
2.00	50.00	SURGERY	2,344	2,344	2.00
3.00	65.00	CARDIOVASCULAR SERVICES	20,892	20,892	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)	615,351	108,183	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151316

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

Worksheet A-8-2

Date/Time Prepared:  
1/26/2012 9:13 am

	Provider Component	RCE Amount	Physician/Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	5.00	6.00	7.00	8.00	9.00	
1.00	507,168	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	507,168	0	0	0	0	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151316

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

Worksheet A-8-2

Date/Time Prepared:  
1/26/2012 9:13 am

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151316

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

Worksheet A-8-2

Date/Time Prepared:  
1/26/2012 9:13 am

	RCE Disallowance	Adjustment	
	17.00	18.00	
1.00	0	84,947	1.00
2.00	0	2,344	2.00
3.00	0	20,892	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	108,183	200.00

		Physical Therapy					Cost	
							1.00	
<b>PART I - GENERAL INFORMATION</b>								
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00	
2.00	Line 1 multiplied by 15 hours per week					780	2.00	
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					614	3.00	
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					1	4.00	
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00	
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00	
7.00	Standard travel expense rate					5.50	7.00	
8.00	Optional travel expense rate per mile					0.00	8.00	
		Supervisors	Therapists	Assistants	Aides	Trainees		
		1.00	2.00	3.00	4.00	5.00		
9.00	Total hours worked	0.00	8,127.00	704.00	2,664.00	0.00	9.00	
10.00	AHSEA (see instructions)	0.00	84.25	54.94	48.84	0.00	10.00	
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	42.13	42.13	27.47			11.00	
12.00	Number of travel hours (provider site)	0	0	0			12.00	
12.01	Number of travel hours (offsite)	0	0	0			12.01	
13.00	Number of miles driven (provider site)	0	0	0			13.00	
13.01	Number of miles driven (offsite)	0	0	0			13.01	
							1.00	
<b>Part II - SALARY EQUIVALENCY COMPUTATION</b>								
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00	
15.00	Therapists (column 2, line 9 times column 2, line 10)					684,700	15.00	
16.00	Assistants (column 3, line 9 times column 3, line 10)					38,678	16.00	
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					723,378	17.00	
18.00	Aides (column 4, line 9 times column 4, line 10)					130,110	18.00	
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00	
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					853,488	20.00	
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.								
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00	
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00	
23.00	Total salary equivalency (see instructions)					853,488	23.00	
<b>PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE</b>								
<b>Standard Travel Allowance</b>								
24.00	Therapists (line 3 times column 2, line 11)					25,868	24.00	
25.00	Assistants (line 4 times column 3, line 11)					27	25.00	
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					25,895	26.00	
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					3,383	27.00	
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					29,278	28.00	
<b>Optional Travel Allowance and Optional Travel Expense</b>								
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12 )					0	29.00	
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00	
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00	
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00	
33.00	Standard travel allowance and standard travel expense (line 28)					0	33.00	
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00	
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00	
<b>Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE</b>								
<b>Standard Travel Expense</b>								
36.00	Therapists (line 5 times column 2, line 11)					0	36.00	
37.00	Assistants (line 6 times column 3, line 11)					0	37.00	
38.00	Subtotal (sum of lines 36 and 37)					0	38.00	
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00	
<b>Optional Travel Allowance and Optional Travel Expense</b>								
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00	
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00	
42.00	Subtotal (sum of lines 40 and 41)					0	42.00	
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00	
<b>Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.</b>								
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00	

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 151316	Period: From 07/01/2010 To 06/30/2011	Worksheet A-8-3 Par Date/Time Prepared: 1/26/2012 9:13 am
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		Physical Therapy				Cost	
						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
<b>PART V - OVERTIME COMPUTATION</b>							
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00	0.00	48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00	0.00	49.00
<b>CALCULATION OF LIMIT</b>							
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
<b>DETERMINATION OF OVERTIME ALLOWANCE</b>							
52.00	Adjusted hourly salary equivalency amount (see instructions)	84.25	54.94	48.84	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00
						1.00	
<b>Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT</b>							
57.00	Salary equivalency amount (from line 23)					853,488	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)					0	59.00
60.00	Overtime allowance (from column 5, line 56)					0	60.00
61.00	Equipment cost (see instructions)					0	61.00
62.00	Supplies (see instructions)					0	62.00
63.00	Total allowance (sum of lines 57-62)					853,488	63.00
64.00	Total cost of outside supplier services (from your records)					702,597	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)					0	65.00
<b>LINE 33 CALCULATION</b>							
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others					25,895	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					3,383	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27					29,278	100.02
<b>LINE 34 CALCULATION</b>							
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					3,383	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	101.01
101.02	Line 34 = sum of lines 27 and 31					3,383	101.02
<b>LINE 35 CALCULATION</b>							
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others					0	102.01
102.02	Line 35 = sum of lines 31 and 32					0	102.02

Cost Center Description	Net Expenses for Cost Allocation (from wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,094,018	1,094,018			1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	1,194,818		1,194,818		2.00
4.00	EMPLOYEE BENEFITS	3,413,927	11,532	12,595	3,438,054	4.00
5.00	ADMINISTRATIVE & GENERAL	3,754,124	83,597	91,299	647,335	4,576,355
6.00	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	OPERATION OF PLANT	1,460,223	114,531	125,083	96,035	1,795,872
7.01	UTILITIES	0	0	0	0	7.01
8.00	LAUNDRY & LINEN SERVICE	111,679	8,698	9,500	0	129,877
9.00	HOUSEKEEPING	395,993	20,238	22,102	111,843	550,176
10.00	DIETARY	189,819	27,543	30,081	67,091	314,534
11.00	CAFETERIA	174,483	12,953	14,147	34,544	236,127
12.00	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	NURSING ADMINISTRATION	867,037	25,704	28,073	338,663	1,259,477
14.00	CENTRAL SERVICES & SUPPLY	123,275	37,258	40,691	58,339	259,563
15.00	PHARMACY	960,420	19,186	20,954	102,614	1,103,174
16.00	MEDICAL RECORDS & LIBRARY	39,462	21,728	23,730	0	84,920
17.00	SOCIAL SERVICE	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	ADULTS & PEDIATRICS	1,615,735	172,695	188,606	603,374	2,580,410
43.00	NURSERY	106,807	3,475	3,795	39,106	153,183
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	OPERATING ROOM	1,148,690	72,983	79,708	191,480	1,492,861
51.00	RECOVERY ROOM	0	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	332,117	15,216	16,618	121,602	485,553
53.00	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	951,014	51,026	55,727	262,572	1,320,339
55.00	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
56.00	RADIOISOTOPE	0	0	0	0	56.00
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	1,478,347	21,693	23,692	275,938	1,799,670
60.01	BLOOD LABORATORY	0	0	0	0	60.01
61.00	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	292,238	10,739	11,728	69,930	384,635
66.00	PHYSICAL THERAPY	726,075	22,884	24,992	380	774,331
67.00	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	53,956	4,032	4,404	22,047	84,439
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
71.30	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	71.30
72.00	IMPL. DEV. CHARGED TO PATIENT	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
75.00	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
91.00	EMERGENCY	1,602,154	35,928	39,238	354,408	2,031,728
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.00	CMHC	0	0	0	0	99.00
99.10	CORF	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1-117)	22,086,411	793,639	866,763	3,397,301	21,417,224
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,775	4,122	0	7,897
191.00	RESEARCH	0	0	0	0	191.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
193.00	NONPAID WORKERS	0	0	0	0	193.00
194.00	OTHER NONREIMBURSABLE - CLINIC	114,109	292,446	319,392	37,995	763,942
194.01	OTHER NONREIMBURSABLE - FOUNDATION	20,180	4,158	4,541	2,758	31,637
194.02	OTHER NONREIMBURSABLE - MARKETING	281,089	0	0	0	281,089
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)	22,501,789	1,094,018	1,194,818	3,438,054	22,501,789

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COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151316

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

Worksheet B  
Part I  
Date/Time Prepared:  
1/26/2012 9:13 am

Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	UTILITIES	LAUNDRY & LINEN SERVICE	
		5.00	6.00	7.00	7.01	8.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL	4,576,355					5.00
6.00	MAINTENANCE & REPAIRS	0	0				6.00
7.00	OPERATION OF PLANT	458,486	0	2,254,358			7.00
7.01	UTILITIES	0	0	0	0		7.01
8.00	LAUNDRY & LINEN SERVICE	33,158	0	22,173	0	185,208	8.00
9.00	HOUSEKEEPING	140,460	0	51,588	0	0	9.00
10.00	DIETARY	80,301	0	70,211	0	2,836	10.00
11.00	CAFETERIA	60,283	0	33,019	0	0	11.00
12.00	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	NURSING ADMINISTRATION	321,544	0	65,524	0	0	13.00
14.00	CENTRAL SERVICES & SUPPLY	66,266	0	94,975	0	2,169	14.00
15.00	PHARMACY	281,640	0	48,908	0	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	21,680	0	55,387	0	0	16.00
17.00	SOCIAL SERVICE	0	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	ADULTS & PEDIATRICS	658,771	0	440,224	0	69,692	30.00
43.00	NURSERY	39,108	0	8,858	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM	381,127	0	186,045	0	21,588	50.00
51.00	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	123,962	0	38,789	0	0	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	337,083	0	130,072	0	30,308	54.00
55.00	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	RADIOISOTOPE	0	0	0	0	0	56.00
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	459,456	0	55,299	0	0	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
61.00	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	98,197	0	27,374	0	0	65.00
66.00	PHYSICAL THERAPY	197,687	0	58,334	0	37,983	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	21,557	0	10,279	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
71.30	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	71.30
72.00	IMPL. DEV. CHARGED TO PATIENT	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
75.00	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	EMERGENCY	518,700	0	91,585	0	20,632	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.00	CMHC	0	0	0	0	0	99.00
99.10	CORF	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00	SUBTOTALS (SUM OF LINES 1-117)	4,299,466	0	1,488,644	0	185,208	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,016	0	9,622	0	0	190.00
191.00	RESEARCH	0	0	0	0	0	191.00
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	OTHER NONREIMBURSABLE - CLINIC	195,034	0	745,494	0	0	194.00
194.01	OTHER NONREIMBURSABLE - FOUNDATION	8,077	0	10,598	0	0	194.01
194.02	OTHER NONREIMBURSABLE - MARKETING	71,762	0	0	0	0	194.02
200.00	Cross Foot Adjustments	0	0	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	4,576,355	0	2,254,358	0	185,208	202.00

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COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151316

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

Worksheet B  
Part I  
Date/Time Prepared:  
1/26/2012 9:13 am

Cost Center Description		HOUSEKEEPING	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	
		9.00	10.00	11.00	12.00	13.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
6.00	MAINTENANCE & REPAIRS						6.00
7.00	OPERATION OF PLANT						7.00
7.01	UTILITIES						7.01
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING	742,224					9.00
10.00	DIETARY	23,898	491,780				10.00
11.00	CAFETERIA	11,239	0	340,668			11.00
12.00	MAINTENANCE OF PERSONNEL	0	0	0	0		12.00
13.00	NURSING ADMINISTRATION	22,303	0	36,224	0	1,705,072	13.00
14.00	CENTRAL SERVICES & SUPPLY	32,327	0	12,612	0	0	14.00
15.00	PHARMACY	16,647	0	11,664	0	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	18,853	0	0	0	0	16.00
17.00	SOCIAL SERVICE	0	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	ADULTS & PEDIATRICS	149,842	491,780	93,886	0	583,549	30.00
43.00	NURSERY	3,015	0	4,891	0	30,397	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM	63,325	0	25,949	0	161,283	50.00
51.00	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	13,203	0	15,206	0	94,515	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	44,273	0	33,468	0	208,020	54.00
55.00	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	RADIOISOTOPE	0	0	0	0	0	56.00
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	18,822	0	37,525	0	233,234	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
61.00	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	9,318	0	8,453	0	52,537	65.00
66.00	PHYSICAL THERAPY	19,856	0	0	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	3,499	0	2,240	0	13,922	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
71.30	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	71.30
72.00	IMPL. DEV. CHARGED TO PATIENT	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
75.00	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	EMERGENCY	31,173	0	52,709	0	327,615	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.00	CMHC	0	0	0	0	0	99.00
99.10	CORF	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00	SUBTOTALS (SUM OF LINES 1-117)	481,593	491,780	334,827	0	1,705,072	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,275	0	0	0	0	190.00
191.00	RESEARCH	0	0	0	0	0	191.00
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	OTHER NONREIMBURSABLE - CLINIC	253,749	0	5,841	0	0	194.00
194.01	OTHER NONREIMBURSABLE - FOUNDATION	3,607	0	0	0	0	194.01
194.02	OTHER NONREIMBURSABLE - MARKETING	0	0	0	0	0	194.02
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)	742,224	491,780	340,668	0	1,705,072	202.00

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COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151316

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

Worksheet B  
Part I  
Date/Time Prepared:  
1/26/2012 9:13 am

Cost Center Description		CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	
		14.00	15.00	16.00	17.00	24.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
6.00	MAINTENANCE & REPAIRS						6.00
7.00	OPERATION OF PLANT						7.00
7.01	UTILITIES						7.01
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING						9.00
10.00	DIETARY						10.00
11.00	CAFETERIA						11.00
12.00	MAINTENANCE OF PERSONNEL						12.00
13.00	NURSING ADMINISTRATION						13.00
14.00	CENTRAL SERVICES & SUPPLY	467,912					14.00
15.00	PHARMACY	1,768	1,463,801				15.00
16.00	MEDICAL RECORDS & LIBRARY	53	0	180,893			16.00
17.00	SOCIAL SERVICE	0	0	0	0		17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	ADULTS & PEDIATRICS	104,213	0	10,750	0	5,183,117	30.00
43.00	NURSERY	7,660	0	1,022	0	248,134	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM	137,873	0	19,792	0	2,489,843	50.00
51.00	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	22,950	0	3,180	0	797,358	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	27,291	0	38,484	0	2,169,338	54.00
55.00	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	RADIOISOTOPE	0	0	0	0	0	56.00
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	31,344	0	33,747	0	2,669,097	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
61.00	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	2,477	0	8,132	0	591,123	65.00
66.00	PHYSICAL THERAPY	994	0	10,449	0	1,099,634	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	399	0	136,335	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
71.30	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	71.30
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	1,463,801	25,451	0	1,489,252	73.00
74.00	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	EMERGENCY	123,659	0	29,487	0	3,227,288	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.00	CMHC	0	0	0	0	0	99.00
99.10	CORF	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00	SUBTOTALS (SUM OF LINES 1-117)	460,282	1,463,801	180,893	0	20,100,519	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	22,810	190.00
191.00	RESEARCH	0	0	0	0	0	191.00
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	OTHER NONREIMBURSABLE - CLINIC	7,630	0	0	0	1,971,690	194.00
194.01	OTHER NONREIMBURSABLE - FOUNDATION	0	0	0	0	53,919	194.01
194.02	OTHER NONREIMBURSABLE - MARKETING	0	0	0	0	352,851	194.02
200.00	Cross Foot Adjustments					0	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	467,912	1,463,801	180,893	0	22,501,789	202.00

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COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151316

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

Worksheet B  
Part I  
Date/Time Prepared:  
1/26/2012 9:13 am

Cost-Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	NEW CAP REL COSTS-BLDG & FIXT			1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP			2.00
4.00	EMPLOYEE BENEFITS			4.00
5.00	ADMINISTRATIVE & GENERAL			5.00
6.00	MAINTENANCE & REPAIRS			6.00
7.00	OPERATION OF PLANT			7.00
7.01	UTILITIES			7.01
8.00	LAUNDRY & LINEN SERVICE			8.00
9.00	HOUSEKEEPING			9.00
10.00	DIETARY			10.00
11.00	CAFETERIA			11.00
12.00	MAINTENANCE OF PERSONNEL			12.00
13.00	NURSING ADMINISTRATION			13.00
14.00	CENTRAL SERVICES & SUPPLY			14.00
15.00	PHARMACY			15.00
16.00	MEDICAL RECORDS & LIBRARY			16.00
17.00	SOCIAL SERVICE			17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	ADULTS & PEDIATRICS	0	5,183,117	30.00
43.00	NURSERY	0	248,134	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	OPERATING ROOM	0	2,489,843	50.00
51.00	RECOVERY ROOM	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	797,358	52.00
53.00	ANESTHESIOLOGY	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	2,169,338	54.00
55.00	RADIOLOGY-THERAPEUTIC	0	0	55.00
56.00	RADIOISOTOPE	0	0	56.00
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	2,669,097	60.00
60.01	BLOOD LABORATORY	0	0	60.01
61.00	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
64.00	INTRAVENOUS THERAPY	0	0	64.00
65.00	RESPIRATORY THERAPY	0	591,123	65.00
66.00	PHYSICAL THERAPY	0	1,099,634	66.00
67.00	OCCUPATIONAL THERAPY	0	0	67.00
68.00	SPEECH PATHOLOGY	0	136,335	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
71.30	IMPL. DEV. CHARGED TO PATIENT	0	0	71.30
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	1,489,252	73.00
74.00	RENAL DIALYSIS	0	0	74.00
75.00	ASC (NON-DISTINCT PART)	0	0	75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
91.00	EMERGENCY	0	3,227,288	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
99.00	CMHC	0	0	99.00
99.10	CORF	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>				
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	20,100,519	118.00
<b>NONREIMBURSABLE COST CENTERS</b>				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	22,810	190.00
191.00	RESEARCH	0	0	191.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
193.00	NONPAID WORKERS	0	0	193.00
194.00	OTHER NONREIMBURSABLE - CLINIC	0	1,971,690	194.00
194.01	OTHER NONREIMBURSABLE - FOUNDATION	0	53,919	194.01
194.02	OTHER NONREIMBURSABLE - MARKETING	0	352,851	194.02
200.00	Cross Foot Adjustments	0	0	200.00
201.00	Negative Cost Centers	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	22,501,789	202.00

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ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151316

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

Worksheet B  
Part II  
Date/Time Prepared:  
1/26/2012 9:13 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	1.00			
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	EMPLOYEE BENEFITS	0	11,532	12,595	24,127	4.00
5.00	ADMINISTRATIVE & GENERAL	0	83,597	91,299	174,896	5.00
6.00	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	OPERATION OF PLANT	0	114,531	125,083	239,614	7.00
7.01	UTILITIES	0	0	0	0	7.01
8.00	LAUNDRY & LINEN SERVICE	0	8,698	9,500	18,198	8.00
9.00	HOUSEKEEPING	0	20,238	22,102	42,340	9.00
10.00	DIETARY	0	27,543	30,081	57,624	10.00
11.00	CAFETERIA	0	12,953	14,147	27,100	11.00
12.00	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	NURSING ADMINISTRATION	0	25,704	28,073	53,777	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	37,258	40,691	77,949	14.00
15.00	PHARMACY	0	19,186	20,954	40,140	15.00
16.00	MEDICAL RECORDS & LIBRARY	0	21,728	23,730	45,458	16.00
17.00	SOCIAL SERVICE	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	ADULTS & PEDIATRICS	0	172,695	188,606	361,301	30.00
43.00	NURSERY	0	3,475	3,795	7,270	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	OPERATING ROOM	0	72,983	79,708	152,691	50.00
51.00	RECOVERY ROOM	0	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	15,216	16,618	31,834	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	51,026	55,727	106,753	54.00
55.00	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
56.00	RADIOISOTOPE	0	0	0	0	56.00
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	21,693	23,692	45,385	60.00
60.01	BLOOD LABORATORY	0	0	0	0	60.01
61.00	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	0	10,739	11,728	22,467	65.00
66.00	PHYSICAL THERAPY	0	22,884	24,992	47,876	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	4,032	4,404	8,436	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
71.30	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	71.30
72.00	IMPL. DEV. CHARGED TO PATIENT	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
75.00	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
91.00	EMERGENCY	0	35,928	39,238	75,166	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.00	CMHC	0	0	0	0	99.00
99.10	CORF	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	793,639	866,763	1,660,402	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,775	4,122	7,897	190.00
191.00	RESEARCH	0	0	0	0	191.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
193.00	NONPAID WORKERS	0	0	0	0	193.00
194.00	OTHER NONREIMBURSABLE - CLINIC	0	292,446	319,392	611,838	194.00
194.01	OTHER NONREIMBURSABLE - FOUNDATION	0	4,158	4,541	8,699	194.01
194.02	OTHER NONREIMBURSABLE - MARKETING	0	0	0	0	194.02
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	1,094,018	1,194,818	2,288,836	202.00

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ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151316

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

Worksheet B  
Part II  
Date/Time Prepared:  
1/26/2012 9:13 am

Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	UTILITIES	LAUNDRY & LINEN SERVICE	
		5.00	6.00	7.00	7.01	8.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL	179,437					5.00
6.00	MAINTENANCE & REPAIRS	0	0				6.00
7.00	OPERATION OF PLANT	17,977	0	258,265			7.00
7.01	UTILITIES	0	0	0	0		7.01
8.00	LAUNDRY & LINEN SERVICE	1,300	0	2,540	0	22,038	8.00
9.00	HOUSEKEEPING	5,507	0	5,910	0	0	9.00
10.00	DIETARY	3,148	0	8,044	0	337	10.00
11.00	CAFETERIA	2,364	0	3,783	0	0	11.00
12.00	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	NURSING ADMINISTRATION	12,607	0	7,507	0	0	13.00
14.00	CENTRAL SERVICES & SUPPLY	2,598	0	10,881	0	258	14.00
15.00	PHARMACY	11,043	0	5,603	0	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	850	0	6,345	0	0	16.00
17.00	SOCIAL SERVICE	0	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	ADULTS & PEDIATRICS	25,833	0	50,433	0	8,293	30.00
43.00	NURSERY	1,533	0	1,015	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM	14,944	0	21,314	0	2,569	50.00
51.00	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	4,860	0	4,444	0	0	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	13,217	0	14,901	0	3,606	54.00
55.00	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	RADIOISOTOPE	0	0	0	0	0	56.00
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	18,015	0	6,335	0	0	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
61.00	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	3,850	0	3,136	0	0	65.00
66.00	PHYSICAL THERAPY	7,751	0	6,683	0	4,520	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	845	0	1,178	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
71.30	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	71.30
72.00	IMPL. DEV. CHARGED TO PATIENT	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
75.00	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	EMERGENCY	20,338	0	10,492	0	2,455	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.00	CMHC	0	0	0	0	0	99.00
99.10	CORF	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00	SUBTOTALS (SUM OF LINES 1-117)	168,580	0	170,544	0	22,038	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	79	0	1,102	0	0	190.00
191.00	RESEARCH	0	0	0	0	0	191.00
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	OTHER NONREIMBURSABLE - CLINIC	7,647	0	85,405	0	0	194.00
194.01	OTHER NONREIMBURSABLE - FOUNDATION	317	0	1,214	0	0	194.01
194.02	OTHER NONREIMBURSABLE - MARKETING	2,814	0	0	0	0	194.02
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)	179,437	0	258,265	0	22,038	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151316

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

Worksheet B  
Part II  
Date/Time Prepared:  
1/26/2012 9:13 am

Cost Center Description		HOUSEKEEPING	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	
		9.00	10.00	11.00	12.00	13.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
6.00	MAINTENANCE & REPAIRS						6.00
7.00	OPERATION OF PLANT						7.00
7.01	UTILITIES						7.01
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING	54,542					9.00
10.00	DIETARY	1,756	71,380				10.00
11.00	CAFETERIA	826	0	34,315			11.00
12.00	MAINTENANCE OF PERSONNEL	0	0	0	0		12.00
13.00	NURSING ADMINISTRATION	1,639	0	3,649	0	81,556	13.00
14.00	CENTRAL SERVICES & SUPPLY	2,376	0	1,270	0	0	14.00
15.00	PHARMACY	1,223	0	1,175	0	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	1,385	0	0	0	0	16.00
17.00	SOCIAL SERVICE	0	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	ADULTS & PEDIATRICS	11,011	71,380	9,457	0	27,912	30.00
43.00	NURSERY	222	0	493	0	1,454	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM	4,653	0	2,614	0	7,714	50.00
51.00	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	970	0	1,532	0	4,521	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	3,253	0	3,371	0	9,950	54.00
55.00	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	RADIOISOTOPE	0	0	0	0	0	56.00
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	1,383	0	3,780	0	11,156	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
61.00	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	685	0	851	0	2,513	65.00
66.00	PHYSICAL THERAPY	1,459	0	0	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	257	0	226	0	666	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
71.30	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	71.30
72.00	IMPL. DEV. CHARGED TO PATIENT	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
75.00	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	EMERGENCY	2,291	0	5,309	0	15,670	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.00	CMHC	0	0	0	0	0	99.00
99.10	CORF	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00	SUBTOTALS (SUM OF LINES 1-117)	35,389	71,380	33,727	0	81,556	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	241	0	0	0	0	190.00
191.00	RESEARCH	0	0	0	0	0	191.00
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	OTHER NONREIMBURSABLE - CLINIC	18,647	0	588	0	0	194.00
194.01	OTHER NONREIMBURSABLE - FOUNDATION	265	0	0	0	0	194.01
194.02	OTHER NONREIMBURSABLE - MARKETING	0	0	0	0	0	194.02
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)	54,542	71,380	34,315	0	81,556	202.00

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ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151316

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

Worksheet B  
Part II  
Date/Time Prepared:  
1/26/2012 9:13 am

Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	
	14.00	15.00	16.00	17.00	24.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 EMPLOYEE BENEFITS						4.00
5.00 ADMINISTRATIVE & GENERAL						5.00
6.00 MAINTENANCE & REPAIRS						6.00
7.00 OPERATION OF PLANT						7.00
7.01 UTILITIES						7.01
8.00 LAUNDRY & LINEN SERVICE						8.00
9.00 HOUSEKEEPING						9.00
10.00 DIETARY						10.00
11.00 CAFETERIA						11.00
12.00 MAINTENANCE OF PERSONNEL						12.00
13.00 NURSING ADMINISTRATION						13.00
14.00 CENTRAL SERVICES & SUPPLY	95,741					14.00
15.00 PHARMACY	362	60,266				15.00
16.00 MEDICAL RECORDS & LIBRARY	11	0	54,049			16.00
17.00 SOCIAL SERVICE	0	0	0	0		17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 ADULTS & PEDIATRICS	21,323	0	3,214	0	594,392	30.00
43.00 NURSERY	1,567	0	306	0	14,134	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 OPERATING ROOM	28,212	0	5,918	0	241,973	50.00
51.00 RECOVERY ROOM	0	0	0	0	0	51.00
52.00 DELIVERY ROOM & LABOR ROOM	4,696	0	951	0	54,661	52.00
53.00 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	5,584	0	11,470	0	173,948	54.00
55.00 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00 RADIOISOTOPE	0	0	0	0	0	56.00
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	6,413	0	10,090	0	104,494	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
61.00 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 RESPIRATORY THERAPY	507	0	2,431	0	36,931	65.00
66.00 PHYSICAL THERAPY	203	0	3,124	0	71,619	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0	0	119	0	11,882	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
71.30 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	71.30
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	60,266	7,610	0	67,876	73.00
74.00 RENAL DIALYSIS	0	0	0	0	0	74.00
75.00 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
91.00 EMERGENCY	25,302	0	8,816	0	168,326	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.00 CMHC	0	0	0	0	0	99.00
99.10 CORF	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00 SUBTOTALS (SUM OF LINES 1-117)	94,180	60,266	54,049	0	1,540,236	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	9,319	190.00
191.00 RESEARCH	0	0	0	0	0	191.00
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 OTHER NONREIMBURSABLE - CLINIC	1,561	0	0	0	725,953	194.00
194.01 OTHER NONREIMBURSABLE - FOUNDATION	0	0	0	0	10,514	194.01
194.02 OTHER NONREIMBURSABLE - MARKETING	0	0	0	0	2,814	194.02
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)	95,741	60,266	54,049	0	2,288,836	202.00

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ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151316

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

Worksheet B  
Part II  
Date/Time Prepared:  
1/26/2012 9:13 am

Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	NEW CAP REL COSTS-BLDG & FIXT			1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP			2.00
4.00	EMPLOYEE BENEFITS			4.00
5.00	ADMINISTRATIVE & GENERAL			5.00
6.00	MAINTENANCE & REPAIRS			6.00
7.00	OPERATION OF PLANT			7.00
7.01	UTILITIES			7.01
8.00	LAUNDRY & LINEN SERVICE			8.00
9.00	HOUSEKEEPING			9.00
10.00	DIETARY			10.00
11.00	CAFETERIA			11.00
12.00	MAINTENANCE OF PERSONNEL			12.00
13.00	NURSING ADMINISTRATION			13.00
14.00	CENTRAL SERVICES & SUPPLY			14.00
15.00	PHARMACY			15.00
16.00	MEDICAL RECORDS & LIBRARY			16.00
17.00	SOCIAL SERVICE			17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	ADULTS & PEDIATRICS	0	594,392	30.00
43.00	NURSERY	0	14,134	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	OPERATING ROOM	0	241,973	50.00
51.00	RECOVERY ROOM	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	54,661	52.00
53.00	ANESTHESIOLOGY	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	173,948	54.00
55.00	RADIOLOGY-THERAPEUTIC	0	0	55.00
56.00	RADIOISOTOPE	0	0	56.00
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	104,494	60.00
60.01	BLOOD LABORATORY	0	0	60.01
61.00	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
64.00	INTRAVENOUS THERAPY	0	0	64.00
65.00	RESPIRATORY THERAPY	0	36,931	65.00
66.00	PHYSICAL THERAPY	0	71,619	66.00
67.00	OCCUPATIONAL THERAPY	0	0	67.00
68.00	SPEECH PATHOLOGY	0	11,882	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
71.30	IMPL. DEV. CHARGED TO PATIENT	0	0	71.30
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	67,876	73.00
74.00	RENAL DIALYSIS	0	0	74.00
75.00	ASC (NON-DISTINCT PART)	0	0	75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
91.00	EMERGENCY	0	168,326	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
99.00	CMHC	0	0	99.00
99.10	CORF	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>				
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	1,540,236	118.00
<b>NONREIMBURSABLE COST CENTERS</b>				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	9,319	190.00
191.00	RESEARCH	0	0	191.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
193.00	NONPAID WORKERS	0	0	193.00
194.00	OTHER NONREIMBURSABLE - CLINIC	0	725,953	194.00
194.01	OTHER NONREIMBURSABLE - FOUNDATION	0	10,514	194.01
194.02	OTHER NONREIMBURSABLE - MARKETING	0	2,814	194.02
200.00	Cross Foot Adjustments	0	0	200.00
201.00	Negative Cost Centers	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	2,288,836	202.00

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COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151316

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

Worksheet B-1

Date/Time Prepared:  
1/26/2012 9:13 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	NEW BLDG. & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 NEW CAP REL COSTS-BLDG & FIXT	157,095					1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP		157,095				2.00
4.00 EMPLOYEE BENEFITS	1,656	1,656	8,323,724			4.00
5.00 ADMINISTRATIVE & GENERAL	12,004	12,004	1,567,241	-4,576,355	17,925,434	5.00
6.00 MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00 OPERATION OF PLANT	16,446	16,446	232,505	0	1,795,872	7.00
7.01 UTILITIES	0	0	0	0	0	7.01
8.00 LAUNDRY & LINEN SERVICE	1,249	1,249	0	0	129,877	8.00
9.00 HOUSEKEEPING	2,906	2,906	270,778	0	550,176	9.00
10.00 DIETARY	3,955	3,955	162,430	0	314,534	10.00
11.00 CAFETERIA	1,860	1,860	83,634	0	236,127	11.00
12.00 MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00 NURSING ADMINISTRATION	3,691	3,691	819,921	0	1,259,477	13.00
14.00 CENTRAL SERVICES & SUPPLY	5,350	5,350	141,242	0	259,563	14.00
15.00 PHARMACY	2,755	2,755	248,435	0	1,103,174	15.00
16.00 MEDICAL RECORDS & LIBRARY	3,120	3,120	0	0	84,920	16.00
17.00 SOCIAL SERVICE	0	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 ADULTS & PEDIATRICS	24,798	24,798	1,460,801	0	2,580,410	30.00
43.00 NURSERY	499	499	94,679	0	153,183	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 OPERATING ROOM	10,480	10,480	463,584	0	1,492,861	50.00
51.00 RECOVERY ROOM	0	0	0	0	0	51.00
52.00 DELIVERY ROOM & LABOR ROOM	2,185	2,185	294,404	0	485,553	52.00
53.00 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	7,327	7,327	635,702	0	1,320,339	54.00
55.00 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00 RADIOISOTOPE	0	0	0	0	0	56.00
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	3,115	3,115	668,062	0	1,799,670	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
61.00 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 RESPIRATORY THERAPY	1,542	1,542	169,304	0	384,635	65.00
66.00 PHYSICAL THERAPY	3,286	3,286	920	0	774,331	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 SPEECH PATHOLOGY	579	579	53,376	0	84,439	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
71.30 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	71.30
72.00 IMPL. DEV. CHARGED TO PATIENT	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
75.00 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
91.00 EMERGENCY	5,159	5,159	858,042	0	2,031,728	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.00 CMHC	0	0	0	0	0	99.00
99.10 CORF	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00 SUBTOTALS (SUM OF LINES 1-117)	113,962	113,962	8,225,060	-4,576,355	16,840,869	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	542	542	0	0	7,897	190.00
191.00 RESEARCH	0	0	0	0	0	191.00
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 OTHER NONREIMBURSABLE - CLINIC	41,994	41,994	91,987	0	763,942	194.00
194.01 OTHER NONREIMBURSABLE - FOUNDATION	597	597	6,677	0	31,637	194.01
194.02 OTHER NONREIMBURSABLE - MARKETING	0	0	0	0	281,089	194.02
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per wkst. B, Part I)	1,094,018	1,194,818	3,438,054		4,576,355	202.00
203.00 Unit cost multiplier (wkst. B, Part I)	6.964054	7.605704	0.413043		0.255300	203.00

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COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151316

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

Worksheet B-1

Date/Time Prepared:  
1/26/2012 9:13 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
204.00 Cost to be allocated (per Wkst. B, Part II)			24,127	5A	179,437	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)			0.002899		0.010010	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151316

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

Worksheet B-1

Date/Time Prepared:  
1/26/2012 9:13 am

Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	UTILITIES	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	
	6.00	7.00	7.01	8.00	9.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 EMPLOYEE BENEFITS						4.00
5.00 ADMINISTRATIVE & GENERAL						5.00
6.00 MAINTENANCE & REPAIRS	0					6.00
7.00 OPERATION OF PLANT	0	126,989				7.00
7.01 UTILITIES	0	0	0			7.01
8.00 LAUNDRY & LINEN SERVICE	0	1,249	0	16,652		8.00
9.00 HOUSEKEEPING	0	2,906	0	0	122,834	9.00
10.00 DIETARY	0	3,955	0	255	3,955	10.00
11.00 CAFETERIA	0	1,860	0	0	1,860	11.00
12.00 MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00 NURSING ADMINISTRATION	0	3,691	0	0	3,691	13.00
14.00 CENTRAL SERVICES & SUPPLY	0	5,350	0	195	5,350	14.00
15.00 PHARMACY	0	2,755	0	0	2,755	15.00
16.00 MEDICAL RECORDS & LIBRARY	0	3,120	0	0	3,120	16.00
17.00 SOCIAL SERVICE	0	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 ADULTS & PEDIATRICS	0	24,798	0	6,266	24,798	30.00
43.00 NURSERY	0	499	0	0	499	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 OPERATING ROOM	0	10,480	0	1,941	10,480	50.00
51.00 RECOVERY ROOM	0	0	0	0	0	51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	2,185	0	0	2,185	52.00
53.00 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	7,327	0	2,725	7,327	54.00
55.00 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00 RADIOISOTOPE	0	0	0	0	0	56.00
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	3,115	0	0	3,115	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
61.00 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 RESPIRATORY THERAPY	0	1,542	0	0	1,542	65.00
66.00 PHYSICAL THERAPY	0	3,286	0	3,415	3,286	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0	579	0	0	579	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
71.30 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	71.30
72.00 IMPL. DEV. CHARGED TO PATIENT	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
75.00 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
91.00 EMERGENCY	0	5,159	0	1,855	5,159	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.00 CMHC	0	0	0	0	0	99.00
99.10 CORF	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	83,856	0	16,652	79,701	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	542	0	0	542	190.00
191.00 RESEARCH	0	0	0	0	0	191.00
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 OTHER NONREIMBURSABLE - CLINIC	0	41,994	0	0	41,994	194.00
194.01 OTHER NONREIMBURSABLE - FOUNDATION	0	597	0	0	597	194.01
194.02 OTHER NONREIMBURSABLE - MARKETING	0	0	0	0	0	194.02
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)	0	2,254,358	0	185,208	742,224	202.00
203.00 Unit cost multiplier (wkst. B, Part I)	0.000000	17.752388	0.000000	11.122268	6.042496	203.00
204.00 Cost to be allocated (per wkst. B, Part II)	0	258,265	0	22,038	54,542	204.00
205.00 Unit cost multiplier (wkst. B, Part II)	0.000000	2.033759	0.000000	1.323445	0.444030	205.00

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COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151316

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

Worksheet B-1

Date/Time Prepared:  
1/26/2012 9:13 am

Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (HOURS OF SERVICE)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NURS HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
	10.00	11.00	12.00	13.00	14.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 EMPLOYEE BENEFITS						4.00
5.00 ADMINISTRATIVE & GENERAL						5.00
6.00 MAINTENANCE & REPAIRS						6.00
7.00 OPERATION OF PLANT						7.00
7.01 UTILITIES						7.01
8.00 LAUNDRY & LINEN SERVICE						8.00
9.00 HOUSEKEEPING						9.00
10.00 DIETARY	15,059					10.00
11.00 CAFETERIA	0	219,772				11.00
12.00 MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00 NURSING ADMINISTRATION	0	23,369	0	176,974		13.00
14.00 CENTRAL SERVICES & SUPPLY	0	8,136	0	0	329,481	14.00
15.00 PHARMACY	0	7,525	0	0	1,245	15.00
16.00 MEDICAL RECORDS & LIBRARY	0	0	0	0	37	16.00
17.00 SOCIAL SERVICE	0	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 ADULTS & PEDIATRICS	15,059	60,568	0	60,568	73,382	30.00
43.00 NURSERY	0	3,155	0	3,155	5,394	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 OPERATING ROOM	0	16,740	0	16,740	97,083	50.00
51.00 RECOVERY ROOM	0	0	0	0	0	51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	9,810	0	9,810	16,160	52.00
53.00 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	21,591	0	21,591	19,217	54.00
55.00 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00 RADIOISOTOPE	0	0	0	0	0	56.00
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	24,208	0	24,208	22,071	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
61.00 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 RESPIRATORY THERAPY	0	5,453	0	5,453	1,744	65.00
66.00 PHYSICAL THERAPY	0	0	0	0	700	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0	1,445	0	1,445	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
71.30 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	71.30
72.00 IMPL. DEV. CHARGED TO PATIENT	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
75.00 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
91.00 EMERGENCY	0	34,004	0	34,004	87,075	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.00 CMHC	0	0	0	0	0	99.00
99.10 CORF	0	0	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00 SUBTOTALS (SUM OF LINES 1-117)	15,059	216,004	0	176,974	324,108	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00 RESEARCH	0	0	0	0	0	191.00
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 OTHER NONREIMBURSABLE - CLINIC	0	3,768	0	0	5,373	194.00
194.01 OTHER NONREIMBURSABLE - FOUNDATION	0	0	0	0	0	194.01
194.02 OTHER NONREIMBURSABLE - MARKETING	0	0	0	0	0	194.02
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)	491,780	340,668	0	1,705,072	467,912	202.00
203.00 Unit cost multiplier (wkst. B, Part I)	32.656883	1.550097	0.000000	9.634590	1.420149	203.00
204.00 Cost to be allocated (per wkst. B, Part II)	71,380	34,315	0	81,556	95,741	204.00

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COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151316

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

worksheet B-1

Date/Time Prepared:  
1/26/2012 9:13 am

Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (HOURS OF SERVICE)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
205.00 Unit cost multiplier (wkst. B, Part II)	4.740023	0.156139	0.000000	0.460836	0.290581	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151316

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

Worksheet B-1

Date/Time Prepared:  
1/26/2012 9:13 am

Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (REVENUES)	SOCIAL SERVICE (TIME SPENT)	
	15.00	16.00	17.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00 NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00 EMPLOYEE BENEFITS				4.00
5.00 ADMINISTRATIVE & GENERAL				5.00
6.00 MAINTENANCE & REPAIRS				6.00
7.00 OPERATION OF PLANT				7.00
7.01 UTILITIES				7.01
8.00 LAUNDRY & LINEN SERVICE				8.00
9.00 HOUSEKEEPING				9.00
10.00 DIETARY				10.00
11.00 CAFETERIA				11.00
12.00 MAINTENANCE OF PERSONNEL				12.00
13.00 NURSING ADMINISTRATION				13.00
14.00 CENTRAL SERVICES & SUPPLY				14.00
15.00 PHARMACY	100			15.00
16.00 MEDICAL RECORDS & LIBRARY	0	62,954,531		16.00
17.00 SOCIAL SERVICE	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00 ADULTS & PEDIATRICS	0	3,741,743	0	30.00
43.00 NURSERY	0	355,852	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00 OPERATING ROOM	0	6,888,988	0	50.00
51.00 RECOVERY ROOM	0	0	0	51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	1,106,742	0	52.00
53.00 ANESTHESIOLOGY	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	13,386,390	0	54.00
55.00 RADIOLOGY-THERAPEUTIC	0	0	0	55.00
56.00 RADIOISOTOPE	0	0	0	56.00
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	0	0	59.00
60.00 LABORATORY	0	11,746,217	0	60.00
60.01 BLOOD LABORATORY	0	0	0	60.01
61.00 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	61.00
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	62.00
63.00 BLOOD STORING, PROCESSING & TRANS.	0	0	0	63.00
64.00 INTRAVENOUS THERAPY	0	0	0	64.00
65.00 RESPIRATORY THERAPY	0	2,830,587	0	65.00
66.00 PHYSICAL THERAPY	0	3,637,121	0	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0	138,772	0	68.00
69.00 ELECTROCARDIOLOGY	0	0	0	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
71.30 IMPL. DEV. CHARGED TO PATIENT	0	0	0	71.30
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	100	8,858,740	0	73.00
74.00 RENAL DIALYSIS	0	0	0	74.00
75.00 ASC (NON-DISTINCT PART)	0	0	0	75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
91.00 EMERGENCY	0	10,263,379	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)				92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
99.00 CMHC	0	0	0	99.00
99.10 CORF	0	0	0	99.10
<b>SPECIAL PURPOSE COST CENTERS</b>				
118.00 SUBTOTALS (SUM OF LINES 1-117)	100	62,954,531	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>				
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	190.00
191.00 RESEARCH	0	0	0	191.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	192.00
193.00 NONPAID WORKERS	0	0	0	193.00
194.00 OTHER NONREIMBURSABLE - CLINIC	0	0	0	194.00
194.01 OTHER NONREIMBURSABLE - FOUNDATION	0	0	0	194.01
194.02 OTHER NONREIMBURSABLE - MARKETING	0	0	0	194.02
200.00 Cross Foot Adjustments				200.00
201.00 Negative Cost Centers				201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	1,463,801	180,893	0	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	14,638.010000	0.002873	0.000000	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	60,266	54,049	0	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)	602.660000	0.000859	0.000000	205.00

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COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151316

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

Worksheet C  
Part I  
Date/Time Prepared:  
1/26/2012 9:13 am

		Title XVIII		Hospital		Cost	
Cost Center Description	Total Cost (from wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	Total Costs	
			Total Costs	RCE Disallowance			
	1:00	2:00	3:00	4:00	5:00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	ADULTS & PEDIATRICS		5,183,117		5,183,117	0	0
43.00	NURSERY		248,134		248,134	0	0
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM		2,489,843		2,489,843	0	0
51.00	RECOVERY ROOM		0		0	0	0
52.00	DELIVERY ROOM & LABOR ROOM		797,358		797,358	0	0
53.00	ANESTHESIOLOGY		0		0	0	0
54.00	RADIOLOGY-DIAGNOSTIC		2,169,338		2,169,338	0	0
55.00	RADIOLOGY-THERAPEUTIC		0		0	0	0
56.00	RADIOISOTOPE		0		0	0	0
57.00	CT SCAN		0		0	0	0
58.00	MAGNETIC RESONANCE IMAGING (MRI)		0		0	0	0
59.00	CARDIAC CATHETERIZATION		0		0	0	0
60.00	LABORATORY		2,669,097		2,669,097	0	0
60.01	BLOOD LABORATORY		0		0	0	0
61.00	PBP CLINICAL LAB SERVICES-PRGM ONLY		0		0	0	0
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS		0		0	0	0
63.00	BLOOD STORING, PROCESSING & TRANS.		0		0	0	0
64.00	INTRAVENOUS THERAPY		0		0	0	0
65.00	RESPIRATORY THERAPY	0	591,123	0	591,123	0	0
66.00	PHYSICAL THERAPY	0	1,099,634	0	1,099,634	0	0
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	0
68.00	SPEECH PATHOLOGY	0	136,335	0	136,335	0	0
69.00	ELECTROCARDIOLOGY		0		0	0	0
70.00	ELECTROENCEPHALOGRAPHY		0		0	0	0
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS		0		0	0	0
71.30	IMPL. DEV. CHARGED TO PATIENT		0		0	0	0
72.00	IMPL. DEV. CHARGED TO PATIENT		0		0	0	0
73.00	DRUGS CHARGED TO PATIENTS		1,489,252		1,489,252	0	0
74.00	RENAL DIALYSIS		0		0	0	0
75.00	ASC (NON-DISTINCT PART)		0		0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	EMERGENCY		3,227,288		3,227,288	0	0
92.00	OBSERVATION BEDS (NON-DISTINCT PART)		670,470		670,470	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.00	CMHC		0		0	0	0
99.10	CORF		0		0	0	0
200.00	Subtotal (see instructions)		20,770,989	0	20,770,989	0	0
201.00	Less Observation Beds		670,470		670,470	0	0
202.00	Total (see instructions)		20,100,519	0	20,100,519	0	0

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151316

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

Worksheet C  
Part I  
Date/Time Prepared:  
1/26/2012 9:13 am

		Title XVIII			Hospital	Cost
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6:00	7:00	8:00			
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	ADULTS & PEDIATRICS	3,741,743		3,741,743		30.00
43.00	NURSERY	355,852		355,852		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	OPERATING ROOM	1,108,086	5,780,902	6,888,988	0.361424	50.00
51.00	RECOVERY ROOM	0	0	0	0.000000	51.00
52.00	DELIVERY ROOM & LABOR ROOM	1,078,473	28,269	1,106,742	0.720455	52.00
53.00	ANESTHESIOLOGY	0	0	0	0.000000	53.00
54.00	RADIOLOGY-DIAGNOSTIC	643,333	12,743,057	13,386,390	0.162055	54.00
55.00	RADIOLOGY-THERAPEUTIC	0	0	0	0.000000	55.00
56.00	RADIOISOTOPE	0	0	0	0.000000	56.00
57.00	CT SCAN	0	0	0	0.000000	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	LABORATORY	1,228,124	10,518,093	11,746,217	0.227230	60.00
60.01	BLOOD LABORATORY	0	0	0	0.000000	60.01
61.00	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0.000000	61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0.000000	62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0.000000	63.00
64.00	INTRAVENOUS THERAPY	0	0	0	0.000000	64.00
65.00	RESPIRATORY THERAPY	1,178,812	1,651,775	2,830,587	0.208834	65.00
66.00	PHYSICAL THERAPY	995,110	2,642,011	3,637,121	0.302336	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0.000000	67.00
68.00	SPEECH PATHOLOGY	36,016	102,755	138,771	0.982446	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0.000000	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	71.00
71.30	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0.000000	71.30
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0.000000	72.00
73.00	DRUGS CHARGED TO PATIENTS	3,245,126	5,613,614	8,858,740	0.168111	73.00
74.00	RENAL DIALYSIS	0	0	0	0.000000	74.00
75.00	ASC (NON-DISTINCT PART)	0	0	0	0.000000	75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
91.00	EMERGENCY	235,949	10,027,430	10,263,379	0.314447	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	25,876	528,884	554,760	1.208577	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.00	CMHC	0	0	0		99.00
99.10	CORF	0	0	0		99.10
200.00	Subtotal (see instructions)	13,872,500	49,636,790	63,509,290		200.00
201.00	Less Observation Beds					201.00
202.00	Total (see instructions)	13,872,500	49,636,790	63,509,290		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151316

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

Worksheet C  
Part I  
Date/Time Prepared:  
1/26/2012 9:13 am

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	Cost
		11.00			
<b>INPATIENT SERVICE COST CENTERS</b>					
30.00	ADULTS & PEDIATRICS				30.00
43.00	NURSERY				43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
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
55.00	RADIOLOGY-THERAPEUTIC	0.000000			55.00
56.00	RADIOISOTOPE	0.000000			56.00
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
60.01	BLOOD LABORATORY	0.000000			60.01
61.00	PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000			61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000			62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0.000000			63.00
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
71.30	IMPL. DEV. CHARGED TO PATIENT	0.000000			71.30
72.00	IMPL. DEV. CHARGED TO PATIENT	0.000000			72.00
73.00	DRUGS CHARGED TO PATIENTS	0.000000			73.00
74.00	RENAL DIALYSIS	0.000000			74.00
75.00	ASC (NON-DISTINCT PART)	0.000000			75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
91.00	EMERGENCY	0.000000			91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
99.00	CMHC				99.00
99.10	CORF				99.10
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: 151316

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

Worksheet C  
Part I  
Date/Time Prepared:  
1/26/2012 9:13 am

Cost Center Description	Total Cost (from wkst. B, Part I, col 26)	Therapy Limit Adj.	Costs		
			Total Costs	RCE	
				Disallowance	Total Costs
1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00 ADULTS & PEDIATRICS	5,183,117		5,183,117	0	0
43.00 NURSERY	248,134		248,134	0	0
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00 OPERATING ROOM	2,489,843		2,489,843	0	0
51.00 RECOVERY ROOM	0		0	0	0
52.00 DELIVERY ROOM & LABOR ROOM	797,358		797,358	0	0
53.00 ANESTHESIOLOGY	0		0	0	0
54.00 RADIOLOGY-DIAGNOSTIC	2,169,338		2,169,338	0	0
55.00 RADIOLOGY-THERAPEUTIC	0		0	0	0
56.00 RADIOISOTOPE	0		0	0	0
57.00 CT SCAN	0		0	0	0
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0
59.00 CARDIAC CATHETERIZATION	0		0	0	0
60.00 LABORATORY	2,669,097		2,669,097	0	0
60.01 BLOOD LABORATORY	0		0	0	0
61.00 PBP CLINICAL LAB SERVICES-PRGM ONLY	0		0	0	0
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0		0	0	0
63.00 BLOOD STORING, PROCESSING & TRANS.	0		0	0	0
64.00 INTRAVENOUS THERAPY	0		0	0	0
65.00 RESPIRATORY THERAPY	591,123	0	591,123	0	0
66.00 PHYSICAL THERAPY	1,099,634	0	1,099,634	0	0
67.00 OCCUPATIONAL THERAPY	0	0	0	0	0
68.00 SPEECH PATHOLOGY	136,335	0	136,335	0	0
69.00 ELECTROCARDIOLOGY	0		0	0	0
70.00 ELECTROENCEPHALOGRAPHY	0		0	0	0
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0
71.30 IMPL. DEV. CHARGED TO PATIENT	0		0	0	0
72.00 IMPL. DEV. CHARGED TO PATIENT	0		0	0	0
73.00 DRUGS CHARGED TO PATIENTS	1,489,252		1,489,252	0	0
74.00 RENAL DIALYSIS	0		0	0	0
75.00 ASC (NON-DISTINCT PART)	0		0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>					
91.00 EMERGENCY	3,227,288		3,227,288	0	0
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	673,025		673,025	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>					
99.00 CMHC	0		0	0	0
99.10 CORF	0		0	0	0
200.00 Subtotal (see instructions)	20,773,544	0	20,773,544	0	0
201.00 Less Observation Beds	673,025		673,025	0	0
202.00 Total (see instructions)	20,100,519	0	20,100,519	0	0

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151316

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

Worksheet C  
Part I  
Date/Time Prepared:  
1/26/2012 9:13 am

		Title XIX			Hospital	Cost
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	ADULTS & PEDIATRICS	3,741,743		3,741,743		30.00
43.00	NURSERY	355,852		355,852		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	OPERATING ROOM	1,108,086	5,780,902	6,888,988	0.361424	50.00
51.00	RECOVERY ROOM	0	0	0	0.000000	51.00
52.00	DELIVERY ROOM & LABOR ROOM	1,078,473	28,269	1,106,742	0.720455	52.00
53.00	ANESTHESIOLOGY	0	0	0	0.000000	53.00
54.00	RADIOLOGY-DIAGNOSTIC	643,333	12,743,057	13,386,390	0.162055	54.00
55.00	RADIOLOGY-THERAPEUTIC	0	0	0	0.000000	55.00
56.00	RADIOISOTOPE	0	0	0	0.000000	56.00
57.00	CT SCAN	0	0	0	0.000000	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	LABORATORY	1,228,124	10,518,093	11,746,217	0.227230	60.00
60.01	BLOOD LABORATORY	0	0	0	0.000000	60.01
61.00	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0.000000	61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0.000000	62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0.000000	63.00
64.00	INTRAVENOUS THERAPY	0	0	0	0.000000	64.00
65.00	RESPIRATORY THERAPY	1,178,812	1,651,775	2,830,587	0.208834	65.00
66.00	PHYSICAL THERAPY	995,110	2,642,011	3,637,121	0.302336	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0.000000	67.00
68.00	SPEECH PATHOLOGY	36,016	102,755	138,771	0.982446	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0.000000	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	71.00
71.30	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0.000000	71.30
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0.000000	72.00
73.00	DRUGS CHARGED TO PATIENTS	3,245,126	5,613,614	8,858,740	0.168111	73.00
74.00	RENAL DIALYSIS	0	0	0	0.000000	74.00
75.00	ASC (NON-DISTINCT PART)	0	0	0	0.000000	75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
91.00	EMERGENCY	235,949	10,027,430	10,263,379	0.314447	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	25,876	528,884	554,760	1.213182	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.00	CMHC	0	0	0		99.00
99.10	CORF	0	0	0		99.10
200.00	Subtotal (see instructions)	13,872,500	49,636,790	63,509,290		200.00
201.00	Less Observation Beds					201.00
202.00	Total (see instructions)	13,872,500	49,636,790	63,509,290		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151316

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

Worksheet C  
Part I  
Date/Time Prepared:  
1/26/2012 9:13 am

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	ADULTS & PEDIATRICS				30.00
43.00	NURSERY				43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
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
55.00	RADIOLOGY-THERAPEUTIC	0.000000			55.00
56.00	RADIOISOTOPE	0.000000			56.00
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
60.01	BLOOD LABORATORY	0.000000			60.01
61.00	PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000			61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000			62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0.000000			63.00
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
71.30	IMPL. DEV. CHARGED TO PATIENT	0.000000			71.30
72.00	IMPL. DEV. CHARGED TO PATIENT	0.000000			72.00
73.00	DRUGS CHARGED TO PATIENTS	0.000000			73.00
74.00	RENAL DIALYSIS	0.000000			74.00
75.00	ASC (NON-DISTINCT PART)	0.000000			75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
91.00	EMERGENCY	0.000000			91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
99.00	CMHC				99.00
99.10	CORF				99.10
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

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

Provider CCN: 151316

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

Worksheet C Part II Date/Time Prepared: 1/26/2012 9:13 am

Cost Center Description	Title XIX					Cost
	Hospital		Hospital		Operating Cost Reduction Amount	
	Capital Cost (wkst. B, Part I, col. 26)	Operating Cost (wkst. B, Part II, col. 26)	Capital Cost (col. 1 - col. 2)	Capital Reduction		
1.00	2.00	3.00	4.00	5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 OPERATING ROOM	2,489,843	241,973	2,247,870	0	0	50.00
51.00 RECOVERY ROOM	0	0	0	0	0	51.00
52.00 DELIVERY ROOM & LABOR ROOM	797,358	54,661	742,697	0	0	52.00
53.00 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	2,169,338	173,948	1,995,390	0	0	54.00
55.00 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00 RADIOISOTOPE	0	0	0	0	0	56.00
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	2,669,097	104,494	2,564,603	0	0	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
61.00 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 RESPIRATORY THERAPY	591,123	36,931	554,192	0	0	65.00
66.00 PHYSICAL THERAPY	1,099,634	71,619	1,028,015	0	0	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 SPEECH PATHOLOGY	136,335	11,882	124,453	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
71.30 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	71.30
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	1,489,252	67,876	1,421,376	0	0	73.00
74.00 RENAL DIALYSIS	0	0	0	0	0	74.00
75.00 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
91.00 EMERGENCY	3,227,288	168,326	3,058,962	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	673,025	0	673,025	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.00 CMHC	0	0	0	0	0	99.00
99.10 CORF	0	0	0	0	0	99.10
200.00 Subtotal (sum of lines 50 thru 199)	15,342,293	931,710	14,410,583	0	0	200.00
201.00 Less Observation Beds	673,025	0	673,025	0	0	201.00
202.00 Total (line 200 minus line 201)	14,669,268	258,685	13,737,558	0	0	202.00

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

Provider CCN: 151316

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

Worksheet C Part II Date/Time Prepared: 1/26/2012 9:13 am

Cost Center Description		Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	Hospital	Cost
		6.00	7.00	8.00		
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	OPERATING ROOM	2,489,843	6,888,988	0.361424		50.00
51.00	RECOVERY ROOM	0	0	0.000000		51.00
52.00	DELIVERY ROOM & LABOR ROOM	797,358	1,106,742	0.720455		52.00
53.00	ANESTHESIOLOGY	0	0	0.000000		53.00
54.00	RADIOLOGY-DIAGNOSTIC	2,169,338	13,386,390	0.162055		54.00
55.00	RADIOLOGY-THERAPEUTIC	0	0	0.000000		55.00
56.00	RADIOISOTOPE	0	0	0.000000		56.00
57.00	CT SCAN	0	0	0.000000		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000		58.00
59.00	CARDIAC CATHETERIZATION	0	0	0.000000		59.00
60.00	LABORATORY	2,669,097	11,746,217	0.227230		60.00
60.01	BLOOD LABORATORY	0	0	0.000000		60.01
61.00	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0.000000		61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.000000		62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000		63.00
64.00	INTRAVENOUS THERAPY	0	0	0.000000		64.00
65.00	RESPIRATORY THERAPY	591,123	2,830,587	0.208834		65.00
66.00	PHYSICAL THERAPY	1,099,634	3,637,121	0.302336		66.00
67.00	OCCUPATIONAL THERAPY	0	0	0.000000		67.00
68.00	SPEECH PATHOLOGY	136,335	138,771	0.982446		68.00
69.00	ELECTROCARDIOLOGY	0	0	0.000000		69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0.000000		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000		71.00
71.30	IMPL. DEV. CHARGED TO PATIENT	0	0	0.000000		71.30
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0.000000		72.00
73.00	DRUGS CHARGED TO PATIENTS	1,489,252	8,858,740	0.168111		73.00
74.00	RENAL DIALYSIS	0	0	0.000000		74.00
75.00	ASC (NON-DISTINCT PART)	0	0	0.000000		75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
91.00	EMERGENCY	3,227,288	10,263,379	0.314447		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	673,025	554,760	1.213182		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.00	CMHC	0	0	0.000000		99.00
99.10	CORF	0	0	0.000000		99.10
200.00	Subtotal (sum of lines 50 thru 199)	15,342,293	0	0		200.00
201.00	Less Observation Beds	673,025	0	0		201.00
202.00	Total (line 200 minus line 201)	14,669,268	122,920,985			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 151316

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

Worksheet D  
Part II  
Date/Time Prepared:  
1/26/2012 9:13 am

		Title XVIII			Hospital	Cost	
Cost Center Description	Capital Related Cost (from wkst. B, Part II, col. 26)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
	1.00	2.00	3.00	4.00	5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM	241,973	6,888,988	0.035125	678,160	23,820	50.00
51.00	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	54,661	1,106,742	0.049389	5,945	294	52.00
53.00	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	173,948	13,386,390	0.012994	377,257	4,902	54.00
55.00	RADIOLOGY-THERAPEUTIC	0	0	0.000000	0	0	55.00
56.00	RADIOISOTOPE	0	0	0.000000	0	0	56.00
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	0	0	0.000000	0	0	59.00
60.00	LABORATORY	104,494	11,746,217	0.008896	793,209	7,056	60.00
60.01	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
61.00	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0.000000	0	0	61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.000000	0	0	62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000	0	0	63.00
64.00	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	RESPIRATORY THERAPY	36,931	2,830,587	0.013047	570,587	7,444	65.00
66.00	PHYSICAL THERAPY	71,619	3,637,121	0.019691	340,289	6,701	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	SPEECH PATHOLOGY	11,882	138,771	0.085623	18,885	1,617	68.00
69.00	ELECTROCARDIOLOGY	0	0	0.000000	0	0	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
71.30	IMPL. DEV. CHARGED TO PATIENT	0	0	0.000000	0	0	71.30
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0.000000	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	67,876	8,858,740	0.007662	2,085,236	15,977	73.00
74.00	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
75.00	ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	EMERGENCY	168,326	10,263,379	0.016401	14,357	235	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	554,760	0.000000	0	0	92.00
200.00	Total (Lines 50-199)	931,710	59,411,695		4,883,925	68,046	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151316

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

Worksheet D  
Part IV  
Date/Time Prepared:  
1/26/2012 9:13 am

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	
<b>ANCILLARY SERVICE COST CENTERS</b>						
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
55.00 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00 RADIOISOTOPE	0	0	0	0	0	56.00
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
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
61.00 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
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
71.30 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	71.30
72.00 IMPL. DEV. CHARGED TO PATIENT	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
75.00 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
91.00 EMERGENCY	0	0	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00 Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151316

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

Worksheet D  
Part IV  
Date/Time Prepared:  
1/26/2012 9:13 am

Cost-Center Description		Title XVIII			Hospital		
		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM	0	6,888,988	0.000000	0.000000	678,160	50.00
51.00	RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	1,106,742	0.000000	0.000000	5,945	52.00
53.00	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	13,386,390	0.000000	0.000000	377,257	54.00
55.00	RADIOLOGY-THERAPEUTIC	0	0	0.000000	0.000000	0	55.00
56.00	RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
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	0	0.000000	0.000000	0	59.00
60.00	LABORATORY	0	11,746,217	0.000000	0.000000	793,209	60.00
60.01	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
61.00	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0.000000	0.000000	0	61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.000000	0.000000	0	62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000	0.000000	0	63.00
64.00	INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0	64.00
65.00	RESPIRATORY THERAPY	0	2,830,587	0.000000	0.000000	570,587	65.00
66.00	PHYSICAL THERAPY	0	3,637,121	0.000000	0.000000	340,289	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	SPEECH PATHOLOGY	0	138,771	0.000000	0.000000	18,885	68.00
69.00	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	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
71.30	IMPL. DEV. CHARGED TO PATIENT	0	0	0.000000	0.000000	0	71.30
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0.000000	0.000000	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	8,858,740	0.000000	0.000000	2,085,236	73.00
74.00	RENAL DIALYSIS	0	0	0.000000	0.000000	0	74.00
75.00	ASC (NON-DISTINCT PART)	0	0	0.000000	0.000000	0	75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	EMERGENCY	0	10,263,379	0.000000	0.000000	14,357	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	554,760	0.000000	0.000000	0	92.00
200.00	Total (lines 50-199)	0	59,411,695			4,883,925	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151316

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

Worksheet D  
Part IV  
Date/Time Prepared:  
1/26/2012 9:13 am

Cost Center Description	Title XVIII			Hospital	Cost	
	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
	11.00	12.00	13.00	21.00	22.00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
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
55.00 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00 RADIOISOTOPE	0	0	0	0	0	56.00
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
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
61.00 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
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
71.30 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	71.30
72.00 IMPL. DEV. CHARGED TO PATIENT	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
75.00 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
91.00 EMERGENCY	0	0	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00 Total (Lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151316

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

Worksheet D  
Part IV  
Date/Time Prepared:  
1/26/2012 9:13 am

Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	Hospital	Cost
		23.00	24.00		
<b>ANCILLARY SERVICE COST CENTERS</b>					
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
55.00	RADIOLOGY-THERAPEUTIC	0	0		55.00
56.00	RADIOISOTOPE	0	0		56.00
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
60.01	BLOOD LABORATORY	0	0		60.01
61.00	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0		61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
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
71.30	IMPL. DEV. CHARGED TO PATIENT	0	0		71.30
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	RENAL DIALYSIS	0	0		74.00
75.00	ASC (NON-DISTINCT PART)	0	0		75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
91.00	EMERGENCY	0	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00	Total (lines 50-199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151316

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

Worksheet D  
Part V  
Date/Time Prepared:  
1/26/2012 9:13 am

		Title XVIII		Hospital		Cost	
Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges					
		PPS-Reimbursed Services (see instructions)	Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	3:00	4:00		
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM	0.361424	0	1,629,880	0		50.00
51.00	RECOVERY ROOM	0.000000	0	0	0		51.00
52.00	DELIVERY ROOM & LABOR ROOM	0.720455	0	0	0		52.00
53.00	ANESTHESIOLOGY	0.000000	0	0	0		53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.162055	0	3,790,624	0		54.00
55.00	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0		55.00
56.00	RADIOISOTOPE	0.000000	0	0	0		56.00
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	0.000000	0	0	0		59.00
60.00	LABORATORY	0.227230	0	3,903,794	0		60.00
60.01	BLOOD LABORATORY	0.000000	0	0	0		60.01
61.00	PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	0	0		61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	0		62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0		63.00
64.00	INTRAVENOUS THERAPY	0.000000	0	0	0		64.00
65.00	RESPIRATORY THERAPY	0.208834	0	448,426	0		65.00
66.00	PHYSICAL THERAPY	0.302336	0	801,703	0		66.00
67.00	OCCUPATIONAL THERAPY	0.000000	0	0	0		67.00
68.00	SPEECH PATHOLOGY	0.982446	0	3,291	0		68.00
69.00	ELECTROCARDIOLOGY	0.000000	0	0	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
71.30	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	0		71.30
72.00	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	0		72.00
73.00	DRUGS CHARGED TO PATIENTS	0.168111	0	2,058,789	3,196		73.00
74.00	RENAL DIALYSIS	0.000000	0	0	0		74.00
75.00	ASC (NON-DISTINCT PART)	0.000000	0	0	0		75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	EMERGENCY	0.314447	0	3,462,706	0		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.208577	0	0	0		92.00
200.00	Subtotal (see instructions)		0	16,099,213	3,196		200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00	Net Charges (line 200 +/- line 201)		0	16,099,213	3,196		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151316

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

Worksheet D  
Part V  
Date/Time Prepared:  
1/26/2012 9:13 am

Cost Center Description	Costs			Hospital	Cost
	PPS Services (see Instructions)	Cost Services Subject To Ded. & Coins. (see Instructions)	Cost Services Not Subject To Ded. & Coins. (see Instructions)		
	5.00	6.00	7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00 OPERATING ROOM	0	589,078	0		50.00
51.00 RECOVERY ROOM	0	0	0		51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00 ANESTHESIOLOGY	0	0	0		53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	614,290	0		54.00
55.00 RADIOLOGY-THERAPEUTIC	0	0	0		55.00
56.00 RADIOISOTOPE	0	0	0		56.00
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	0	0		59.00
60.00 LABORATORY	0	887,059	0		60.00
60.01 BLOOD LABORATORY	0	0	0		60.01
61.00 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0		61.00
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0		62.00
63.00 BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
64.00 INTRAVENOUS THERAPY	0	0	0		64.00
65.00 RESPIRATORY THERAPY	0	93,647	0		65.00
66.00 PHYSICAL THERAPY	0	242,384	0		66.00
67.00 OCCUPATIONAL THERAPY	0	0	0		67.00
68.00 SPEECH PATHOLOGY	0	3,233	0		68.00
69.00 ELECTROCARDIOLOGY	0	0	0		69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
71.30 IMPL. DEV. CHARGED TO PATIENT	0	0	0		71.30
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	0	346,105	537		73.00
74.00 RENAL DIALYSIS	0	0	0		74.00
75.00 ASC (NON-DISTINCT PART)	0	0	0		75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
91.00 EMERGENCY	0	1,088,838	0		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00 Subtotal (see instructions)	0	3,864,634	537		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00 Net Charges (line 200 +/- line 201)	0	3,864,634	537		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151316 Component CCN: 152316	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part V Date/Time Prepared: 1/26/2012 9:13 am
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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)	Cost	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	OPERATING ROOM	0.361424	0	0	0	50.00
51.00	RECOVERY ROOM	0.000000	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0.720455	0	0	0	52.00
53.00	ANESTHESIOLOGY	0.000000	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.162055	0	0	0	54.00
55.00	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	55.00
56.00	RADIOISOTOPE	0.000000	0	0	0	56.00
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	0.000000	0	0	0	59.00
60.00	LABORATORY	0.227230	0	0	0	60.00
60.01	BLOOD LABORATORY	0.000000	0	0	0	60.01
61.00	PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	0	0	61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	0	62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	63.00
64.00	INTRAVENOUS THERAPY	0.000000	0	0	0	64.00
65.00	RESPIRATORY THERAPY	0.208834	0	0	0	65.00
66.00	PHYSICAL THERAPY	0.302336	0	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0.000000	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0.982446	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0.000000	0	0	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
71.30	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	0	71.30
72.00	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.168111	0	0	0	73.00
74.00	RENAL DIALYSIS	0.000000	0	0	0	74.00
75.00	ASC (NON-DISTINCT PART)	0.000000	0	0	0	75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
91.00	EMERGENCY	0.314447	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.208577	0	0	0	92.00
200.00	Subtotal (see instructions)		0	0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151316 Component CCN:152316	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part V Date/Time Prepared: 1/26/2012 9:13 am
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Cost Center Description	Costs			Swing Beds - SNF	Cost
	PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)		
	5.00	6.00	7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00 OPERATING ROOM	0	0	0		50.00
51.00 RECOVERY ROOM	0	0	0		51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00 ANESTHESIOLOGY	0	0	0		53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
55.00 RADIOLOGY-THERAPEUTIC	0	0	0		55.00
56.00 RADIOISOTOPE	0	0	0		56.00
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	0	0		59.00
60.00 LABORATORY	0	0	0		60.00
60.01 BLOOD LABORATORY	0	0	0		60.01
61.00 PBP CLINICAL LAB SERVICES-PRGM ONLY		0			61.00
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0		62.00
63.00 BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
64.00 INTRAVENOUS THERAPY	0	0	0		64.00
65.00 RESPIRATORY THERAPY	0	0	0		65.00
66.00 PHYSICAL THERAPY	0	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	0	0	0		69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
71.30 IMPL. DEV. CHARGED TO PATIENT	0	0	0		71.30
72.00 IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
74.00 RENAL DIALYSIS	0	0	0		74.00
75.00 ASC (NON-DISTINCT PART)	0	0	0		75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
91.00 EMERGENCY	0	0	0		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00 Subtotal (see instructions)	0	0	0		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00 Net Charges (line 200 +/- line 201)	0	0	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 151316		Period: From 07/01/2010 To 06/30/2011		Worksheet D Part I Date/Time Prepared: 1/26/2012 9:13 am	
Cost Center Description		Capital Related Cost (from wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Cost Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	ADULTS & PEDIATRICS	594,392	102,954	491,438	3,623	135.64	30.00
43.00	NURSERY	14,134		14,134	423	33.41	43.00
200.00	Total (lines 30-199)	608,526		505,572	4,046		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 151316	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part I Date/Time Prepared: 1/26/2012 9:13 am
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	Cost
		6.00	7.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	ADULTS & PEDIATRICS	466	63,208	30.00
43.00	NURSERY	184	6,147	43.00
200.00	Total (lines 30-199)	650	69,355	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 151316

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

Worksheet D  
Part II  
Date/Time Prepared:  
1/26/2012 9:13 am

		Title XIX			Hospital	Cost	
Cost Center Description		Capital Related Cost (from wkst. B, Part II, col. 26)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM	241,973	6,888,988	0.035125	349,297	12,269	50.00
51.00	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	54,661	1,106,742	0.049389	0	0	52.00
53.00	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	173,948	13,386,390	0.012994	37,677	490	54.00
55.00	RADIOLOGY-THERAPEUTIC	0	0	0.000000	0	0	55.00
56.00	RADIOISOTOPE	0	0	0.000000	0	0	56.00
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	0	0	0.000000	0	0	59.00
60.00	LABORATORY	104,494	11,746,217	0.008896	211,047	1,877	60.00
60.01	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
61.00	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0.000000	0	0	61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.000000	0	0	62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000	0	0	63.00
64.00	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	RESPIRATORY THERAPY	36,931	2,830,587	0.013047	87,049	1,136	65.00
66.00	PHYSICAL THERAPY	71,619	3,637,121	0.019691	19,584	386	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	SPEECH PATHOLOGY	11,882	138,771	0.085623	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	0.000000	0	0	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
71.30	IMPL. DEV. CHARGED TO PATIENT	0	0	0.000000	0	0	71.30
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0.000000	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	67,876	8,858,740	0.007662	276,660	2,120	73.00
74.00	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
75.00	ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	EMERGENCY	168,326	10,263,379	0.016401	56,184	921	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	554,760	0.000000	0	0	92.00
200.00	Total (lines 50-199)	931,710	59,411,695		1,037,498	19,199	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 151316		Period: From 07/01/2010 To 06/30/2011		Worksheet D Part III Date/Time Prepared: 1/26/2012 9:13 am	
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 3, minus col. 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
43.00	NURSERY	0	0	0	0	0	43.00
200.00	Total (lines 30-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 151316		Period: From 07/01/2010 To 06/30/2011		worksheet D Part III Date/Time Prepared: 1/26/2012 9:13 am	
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. Nursing School
			6.00	7.00	8.00	9.00	11.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	ADULTS & PEDIATRICS		3,623	0.00	466	0	0 30.00
43.00	NURSERY		423	0.00	184	0	0 43.00
200.00	Total (lines 30-199)		4,046		650	0	0 200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151316	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part III Date/Time Prepared: 1/26/2012 9:13 am
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Cost Center Description	Title XIX		Hospital	Cost
	PSA Adj. Allied Health Cost	PSA Adj. All Other Medical Education Cost		
	12.00	13.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00 ADULTS & PEDIATRICS	0	0		30.00
43.00 NURSERY	0	0		43.00
200.00 Total (lines 30-199)	0	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151316

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

Worksheet D  
Part IV  
Date/Time Prepared:  
1/26/2012 9:13 am

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	
<b>ANCILLARY SERVICE COST CENTERS</b>						
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
55.00 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00 RADIOISOTOPE	0	0	0	0	0	56.00
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
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
61.00 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
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
71.30 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	71.30
72.00 IMPL. DEV. CHARGED TO PATIENT	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
75.00 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
91.00 EMERGENCY	0	0	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00 Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151316

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

Worksheet D Part IV Date/Time Prepared: 1/26/2012 9:13 am

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		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	OPERATING ROOM	0	6,888,988	0.000000	0.000000	349,297	0	50.00
51.00	RECOVERY ROOM	0	0	0.000000	0.000000	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	1,106,742	0.000000	0.000000	0	0	52.00
53.00	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	13,386,390	0.000000	0.000000	37,677	0	54.00
55.00	RADIOLOGY-THERAPEUTIC	0	0	0.000000	0.000000	0	0	55.00
56.00	RADIOISOTOPE	0	0	0.000000	0.000000	0	0	56.00
57.00	CT SCAN	0	0	0.000000	0.000000	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	0	59.00
60.00	LABORATORY	0	11,746,217	0.000000	0.000000	211,047	0	60.00
60.01	BLOOD LABORATORY	0	0	0.000000	0.000000	0	0	60.01
61.00	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0.000000	0.000000	0	0	61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.000000	0.000000	0	0	62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000	0.000000	0	0	63.00
64.00	INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0	0	64.00
65.00	RESPIRATORY THERAPY	0	2,830,587	0.000000	0.000000	87,049	0	65.00
66.00	PHYSICAL THERAPY	0	3,637,121	0.000000	0.000000	19,584	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	0	67.00
68.00	SPEECH PATHOLOGY	0	138,771	0.000000	0.000000	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	0	71.00
71.30	IMPL. DEV. CHARGED TO PATIENT	0	0	0.000000	0.000000	0	0	71.30
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0	0.000000	0.000000	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	8,858,740	0.000000	0.000000	276,660	0	73.00
74.00	RENAL DIALYSIS	0	0	0.000000	0.000000	0	0	74.00
75.00	ASC (NON-DISTINCT PART)	0	0	0.000000	0.000000	0	0	75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
91.00	EMERGENCY	0	10,263,379	0.000000	0.000000	56,184	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	554,760	0.000000	0.000000	0	0	92.00
200.00	Total (lines 50-199)	0	59,411,695			1,037,498	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151316

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

Worksheet D  
Part IV  
Date/Time Prepared:  
1/26/2012 9:13 am

Cost Center Description	Title XIX			Hospital	Cost	
	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
	11.00	12.00	13.00	21.00	22.00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
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
55.00 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00 RADIOISOTOPE	0	0	0	0	0	56.00
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
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
61.00 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
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
71.30 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	71.30
72.00 IMPL. DEV. CHARGED TO PATIENT	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
75.00 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
91.00 EMERGENCY	0	0	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00 Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151316

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

Worksheet D  
Part IV  
Date/Time Prepared:  
1/26/2012 9:13 am

Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	Title XIX	Hospital	Cost
		23.00	24.00			
<b>ANCILLARY SERVICE COST CENTERS</b>						
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
55.00	RADIOLOGY-THERAPEUTIC	0	0			55.00
56.00	RADIOISOTOPE	0	0			56.00
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
60.01	BLOOD LABORATORY	0	0			60.01
61.00	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0			61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0			62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0			63.00
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
71.30	IMPL. DEV. CHARGED TO PATIENT	0	0			71.30
72.00	IMPL. DEV. CHARGED TO PATIENT	0	0			72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0			73.00
74.00	RENAL DIALYSIS	0	0			74.00
75.00	ASC (NON-DISTINCT PART)	0	0			75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
91.00	EMERGENCY	0	0			91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0			92.00
200.00	Total (lines 50-199)	0	0			200.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 151316	Period: From 07/01/2010 To 06/30/2011	Worksheet D-1 Date/Time Prepared: 1/26/2012 9:13 am
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Cost Center Description	Title XVIII	Hospital	Cost
<b>PART I - ALL PROVIDER COMPONENTS</b>			
<b>INPATIENT DAYS</b>			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		4,516 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,623 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)		3,623 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		384 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)		375 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		68 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)		66 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		1,916 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)		384 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)		375 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
<b>SWING-BED ADJUSTMENT</b>			
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00 17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00 18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		146.75 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		146.75 20.00
21.00	Total general inpatient routine service cost (see instructions)		5,183,117 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)		9,979 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)		9,686 25.00
26.00	Total swing-bed cost (see instructions)		914,017 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		4,269,100 27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>			
28.00	General inpatient routine service charges (excluding swing-bed charges)		3,149,269 28.00
29.00	Private room charges (excluding swing-bed charges)		0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)		3,149,269 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		1.355584 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)		869.24 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)		4,269,100 37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>			
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>			
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,178.33 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,257,680 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)		2,257,680 41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151316		Period: From 07/01/2010 To 06/30/2011		Worksheet D-1 Date/Time Prepared: 1/26/2012 9:13 am	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Cost	
		1.00	2.00	3.00	4.00	Program Cost (col. 3 x col. 4)	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
<b>Intensive Care Type Inpatient Hospital Units</b>							
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
<b>Cost Center Description</b>							
48.00	Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					1,086,422	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					3,344,102	49.00
<b>PASS THROUGH COST ADJUSTMENTS</b>							
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
<b>TARGET AMOUNT AND LIMIT COMPUTATION</b>							
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
<b>PROGRAM INPATIENT ROUTINE SWING BED COST</b>							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					452,479	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					441,874	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					894,353	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
<b>PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY</b>							
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
<b>PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>							
87.00	Total observation bed days (see instructions)					569	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,178.33	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					670,470	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151316

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

Worksheet D-1  
Date/Time Prepared:  
1/26/2012 9:13 am

Cost Center Description	Cost	Title XVIII		Hospital	Cost	
		Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
	1.00	2.00	3.00	4.00	5.00	
<b>COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>						
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: 151316

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

Worksheet D-1

Date/Time Prepared:  
1/26/2012 9:13 am

Cost Center Description	Title XIX	Hospital	Cost	
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		4,516	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,623	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)		3,623	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		384	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)		375	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		68	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)		66	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		466	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)		423	15.00
16.00	Nursery days (title V or XIX only)		184	16.00
<b>SWING BED ADJUSTMENT</b>				
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)		5,183,117	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)		897,760	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		4,285,357	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed charges)		3,149,269	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		3,149,269	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		1.360747	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)		869.24	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)		4,285,357	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,182.82	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		551,194	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)		551,194	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151316

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

Worksheet D-1

Date/Time Prepared:  
1/26/2012 9:13 am

Cost Center Description	Title XIX			Hospital		Cost
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
42.00 NURSERY (title V & XIX only)	248,134	423	586.61	184	107,936	42.00
<b>Intensive Care Type Inpatient Hospital Units</b>						
43.00 INTENSIVE CARE UNIT						43.00
44.00 CORONARY CARE UNIT						44.00
45.00 BURN INTENSIVE CARE UNIT						45.00
46.00 SURGICAL INTENSIVE CARE UNIT						46.00
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00
<b>Cost Center Description</b>						
					1.00	
48.00 Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					268,583	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					927,713	49.00
<b>PASS THROUGH COST ADJUSTMENTS</b>						
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
<b>TARGET AMOUNT AND LIMIT COMPUTATION</b>						
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
<b>PROGRAM INPATIENT ROUTINE SWING BED COST</b>						
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
<b>PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY</b>						
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
<b>PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>						
87.00 Total observation bed days (see instructions)					569	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,182.82	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					673,025	89.00

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COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151316

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

worksheet D-1

Date/Time Prepared:  
1/26/2012 9:13 am

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 151316	Period: From 07/01/2010 To 06/30/2011	Worksheet D-3 Date/Time Prepared: 1/26/2012 9:13 am
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Cost Center Description		Ratio of Cost To Charges	Hospital Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	Cost
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	ADULTS & PEDIATRICS		1,518,841		30.00
43.00	NURSERY				43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	OPERATING ROOM	0.361424	678,160	245,103	50.00
51.00	RECOVERY ROOM	0.000000	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0.720455	5,945	4,283	52.00
53.00	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.162055	377,257	61,136	54.00
55.00	RADIOLOGY-THERAPEUTIC	0.000000	0	0	55.00
56.00	RADIOISOTOPE	0.000000	0	0	56.00
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	0.000000	0	0	59.00
60.00	LABORATORY	0.227230	793,209	180,241	60.00
60.01	BLOOD LABORATORY	0.000000	0	0	60.01
61.00	PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	0	61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	63.00
64.00	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	RESPIRATORY THERAPY	0.208834	570,587	119,158	65.00
66.00	PHYSICAL THERAPY	0.302336	340,289	102,882	66.00
67.00	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	SPEECH PATHOLOGY	0.982446	18,885	18,553	68.00
69.00	ELECTROCARDIOLOGY	0.000000	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
71.30	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	71.30
72.00	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.168111	2,085,236	350,551	73.00
74.00	RENAL DIALYSIS	0.000000	0	0	74.00
75.00	ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
91.00	EMERGENCY	0.314447	14,357	4,515	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.208577	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		4,883,925	1,086,422	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		4,883,925		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 151316

Period: From 07/01/2010

Worksheet D-3

Component CCN: 152316

To 06/30/2011

Date/Time Prepared: 1/26/2012 9:13 am

Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	Cost
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	ADULTS & PEDIATRICS		245,658		30.00
43.00	NURSERY				43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	OPERATING ROOM	0.361424	9,626	3,479	50.00
51.00	RECOVERY ROOM	0.000000	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0.720455	0	0	52.00
53.00	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.162055	15,551	2,520	54.00
55.00	RADIOLOGY-THERAPEUTIC	0.000000	0	0	55.00
56.00	RADIOISOTOPE	0.000000	0	0	56.00
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	0.000000	0	0	59.00
60.00	LABORATORY	0.227230	55,832	12,687	60.00
60.01	BLOOD LABORATORY	0.000000	0	0	60.01
61.00	PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	0	61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	63.00
64.00	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	RESPIRATORY THERAPY	0.208834	72,445	15,129	65.00
66.00	PHYSICAL THERAPY	0.302336	559,435	169,137	66.00
67.00	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	SPEECH PATHOLOGY	0.982446	12,258	12,043	68.00
69.00	ELECTROCARDIOLOGY	0.000000	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
71.30	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	71.30
72.00	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.168111	493,239	82,919	73.00
74.00	RENAL DIALYSIS	0.000000	0	0	74.00
75.00	ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
91.00	EMERGENCY	0.314447	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.208577	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		1,218,386	297,914	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		1,218,386	0	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 151316

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

Worksheet D-3

Date/Time Prepared:  
1/26/2012 9:13 am

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			
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	ADULTS & PEDIATRICS		1,384,770				30.00
43.00	NURSERY		0				43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	OPERATING ROOM	0.361424	349,297	126,244			50.00
51.00	RECOVERY ROOM	0.000000	0	0			51.00
52.00	DELIVERY ROOM & LABOR ROOM	0.720455	0	0			52.00
53.00	ANESTHESIOLOGY	0.000000	0	0			53.00
54.00	RADIOLOGY-DIAGNOSTIC	0.162055	37,677	6,106			54.00
55.00	RADIOLOGY-THERAPEUTIC	0.000000	0	0			55.00
56.00	RADIOISOTOPE	0.000000	0	0			56.00
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	0.000000	0	0			59.00
60.00	LABORATORY	0.227230	211,047	47,956			60.00
60.01	BLOOD LABORATORY	0.000000	0	0			60.01
61.00	PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	0			61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0			62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0			63.00
64.00	INTRAVENOUS THERAPY	0.000000	0	0			64.00
65.00	RESPIRATORY THERAPY	0.208834	87,049	18,179			65.00
66.00	PHYSICAL THERAPY	0.302336	19,584	5,921			66.00
67.00	OCCUPATIONAL THERAPY	0.000000	0	0			67.00
68.00	SPEECH PATHOLOGY	0.982446	0	0			68.00
69.00	ELECTROCARDIOLOGY	0.000000	0	0			69.00
70.00	ELECTROENCEPHALOGRAPHY	0.000000	0	0			70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0			71.00
71.30	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0			71.30
72.00	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0			72.00
73.00	DRUGS CHARGED TO PATIENTS	0.168111	276,660	46,510			73.00
74.00	RENAL DIALYSIS	0.000000	0	0			74.00
75.00	ASC (NON-DISTINCT PART)	0.000000	0	0			75.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
91.00	EMERGENCY	0.314447	56,184	17,667			91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.213182	0	0			92.00
200.00	Total (sum of lines 50-94 and 96-98)		1,037,498	268,583			200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0			201.00
202.00	Net Charges (line 200 minus line 201)		1,037,498				202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151316	Period: From 07/01/2010 To 06/30/2011	Worksheet E Part B Date/Time Prepared: 1/26/2012 9:13 am
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		Title XVIII	Hospital	Cost
				1.00
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)			3,865,171 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			0 2.00
3.00	PPS payments			0 3.00
4.00	Outlier payment (see instructions)			0 4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000 5.00
6.00	Line 2 times line 5			0 6.00
7.00	Sum of line 3 plus line 4 divided by line 6			0.00 7.00
8.00	Transitional corridor payment (see instructions)			0 8.00
9.00	Ancillary service other pass through costs from worksheet D, Part IV, column 13, line 200			0 9.00
10.00	Organ acquisitions			0 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			3,865,171 11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
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
<b>Customary charges</b>				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR 413.13(e)			0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000 17.00
18.00	Total customary charges (see instructions)			0 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0 19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0 20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)			3,903,823 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
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance (for CAH, see instructions)			32,753 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			2,476,999 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)			1,394,071 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)			1,394,071 30.00
31.00	Primary payer payments			570 31.00
32.00	Subtotal (line 30 minus line 31)			1,393,501 32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from worksheet I-5, line 11)			0 33.00
34.00	Allowable bad debts (see instructions)			561,556 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			561,556 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			522,331 36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)			1,955,057 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)			1,955,057 40.00
41.00	Interim payments			1,727,109 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)			227,948 43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			0 44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
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

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CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151316	Period: From 07/01/2010 To 06/30/2011	Worksheet E Part B Date/Time Prepared: 1/26/2012 9:13 am
Title XVIII		Hospital	Cost
<b>WORKSHEET OVERRIDE VALUES</b>			Overrides
112.00 override of Ancillary service charges (line 12)			1.00
			0112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151316

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
1/26/2012 9:13 am

		Title XVIII		Hospital		Cost	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		2,721,597		2,076,900		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
<b>Program to Provider</b>							
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
<b>Provider to Program</b>							
3.50	ADJUSTMENTS TO PROGRAM	02/03/2011	44,456	02/03/2011	114,037		3.50
3.51		06/28/2011	57,786	06/28/2011	235,754		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)		-102,242		-349,791		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)		2,619,355		1,727,109		4.00
<b>TO BE COMPLETED BY CONTRACTOR</b>							
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
<b>Program to Provider</b>							
5.01	TENTATIVE TO PROVIDER		0		0		5.01
5.02			0		0		5.02
5.03			0		0		5.03
<b>Provider to Program</b>							
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		470,294		227,948		6.01
6.02	SETTLEMENT TO PROGRAM		0		0		6.02
7.00	Total Medicare program liability (see instructions)		3,089,649		1,955,057		7.00
				Contractor Number	Date (Mo/Day/Yr)		
				0	1.00	2.00	
8.00	Name of Contractor						8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151316

Period: From 07/01/2010

Worksheet E-1

Component CCN: 152316

To 06/30/2011

Part I  
Date/Time Prepared:  
1/26/2012 9:13 am

		Title XVIII		Swing Beds - SNF		Cost	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		1,065,219		0		1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0		2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
<b>Program to Provider</b>							
3.01	ADJUSTMENTS TO PROVIDER	06/28/2011	18,531		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
<b>Provider to Program</b>							
3.50	ADJUSTMENTS TO PROGRAM	02/03/2011	23,433		0		3.50
3.51		06/28/2011	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)		-4,902		0		3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to wkst. E or wkst. E-3, line and column as appropriate)		1,060,317		0		4.00
<b>TO BE COMPLETED BY CONTRACTOR</b>							
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
<b>Program to Provider</b>							
5.01	TENTATIVE TO PROVIDER		0		0		5.01
5.02			0		0		5.02
5.03			0		0		5.03
<b>Provider to Program</b>							
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		129,413		0		6.01
6.02	SETTLEMENT TO PROGRAM		0		0		6.02
7.00	Total Medicare program liability (see instructions)		1,189,730		0		7.00
				Contractor Number	Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor						8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 151316	Period: From 07/01/2010 To 06/30/2011	Worksheet E-2
	Component CCN: 152316		Date/Time Prepared: 1/26/2012 9:13 am

		Title XVIII		Swing Beds - SNF		Cost	
		Part A		Part B			
		1:00		2:00			
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>							
1.00	Inpatient routine services - swing bed-SNF (see instructions)	903,297		0		1.00	
2.00	Inpatient routine services - swing bed-NF (see instructions)					2.00	
3.00	Ancillary services (from wkst. D-3, column 3, line 200 for Part A, and sum of wkst. D, Part V, columns 5 and 7, line 202 for Part B) (For CAH, see instructions)	300,893		0		3.00	
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)				0.00	4.00	
5.00	Program days	759		0		5.00	
6.00	Interns and residents not in approved teaching program (see instructions)			0		6.00	
7.00	Utilization review - physician compensation - SNF optional method only	0				7.00	
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	1,204,190		0		8.00	
9.00	Primary payer payments (see instructions)	0		0		9.00	
10.00	Subtotal (line 8 minus line 9)	1,204,190		0		10.00	
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0		0		11.00	
12.00	Subtotal (line 10 minus line 11)	1,204,190		0		12.00	
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	14,460		0		13.00	
14.00	80% of Part B costs (line 12 x 80%)					14.00	
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	1,189,730		0		15.00	
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0		0		16.00	
17.00	Reimbursable bad debts (see instructions)	0		0		17.00	
18.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0		0		18.00	
19.00	Total (sum of lines 15 and 17, plus/minus line 16)	1,189,730		0		19.00	
20.00	Interim payments	1,060,317		0		20.00	
21.00	Tentative settlement (for contractor use only)	0		0		21.00	
22.00	Balance due provider/program (line 19 minus the sum of lines 20 and 21)	129,413		0		22.00	
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0		0		23.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151316	Period: From 07/01/2010 To 06/30/2011	Worksheet E-3 Part V Date/Time Prepared: 1/26/2012 9:13 am
		Title XVIII	Hospital	Cost

				1.00	
<b>PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)</b>					
1.00	Inpatient services		3,344,102		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)		3,344,102		4.00
5.00	Primary payer payments		0		5.00
6.00	Total cost (line 5 less line 6) . For CAH (see instructions)		3,377,543		6.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>					
<b>Reasonable charges</b>					
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
<b>Customary charges</b>					
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
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>					
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)		3,377,543		19.00
20.00	Deductibles (exclude professional component)		342,486		20.00
21.00	Excess reasonable cost (from line 16)		0		21.00
22.00	Subtotal (line 19 minus sum of lines 20 and 21)		3,035,057		22.00
23.00	Coinsurance		5,540		23.00
24.00	Subtotal (line 22 minus line 23)		3,029,517		24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		60,132		25.00
26.00	Adjusted reimbursable bad debts (see instructions)		60,132		26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		53,220		27.00
28.00	Subtotal (sum of lines 24 and 25 or 26(line 26 hospital and subprovider only))		3,089,649		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)		3,089,649		30.00
31.00	Interim payments		2,619,355		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)		470,294		33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		0		34.00

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CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151316	Period: From 07/01/2010 To 06/30/2011	Worksheet E-3 Part VII Date/Time Prepared: 1/26/2012 9:13 am
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	Title XIX	Hospital	Cost
			1.00

PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	927,713	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)	927,713	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)	927,713	7.00
COMPUTATION OF LESSER OF COST OR CHARGES			
Reasonable Charges:			
8.00	Routine service charges	1,384,770	8.00
9.00	Ancillary service charges	1,037,498	9.00
10.00	Organ acquisition charges, net of revenue	0	10.00
11.00	Incentive from target amount computation	0	11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	2,422,268	12.00
CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	15.00
16.00	Total customary charges (see instructions)	2,422,268	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 7) (see instructions)	1,494,555	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 7 exceeds line 16) (see instructions)	0	18.00
19.00	Interns and Residents (see instructions)	0	19.00
20.00	Cost of Teaching Physicians (see instructions)	0	20.00
21.00	Cost of covered services (line 7)	927,713	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 XIX PPS covered services only)	0	28.00
29.00	Titles V or XIX (see instructions)	927,713	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus line 29 minus line 30)	927,713	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)	927,713	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	37.00
38.00	Subtotal (line 36 ± line 37)	927,713	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)	927,713	40.00
41.00	Interim payments	927,713	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: 151316

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

Worksheet G

Date/Time Prepared:  
1/26/2012 9:13 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>CURRENT ASSETS</b>						
1.00	Cash on hand in banks	1,789,980	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	7,812,827	0	0	0	4.00
5.00	Other receivable	10,366	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-5,133,505	0	0	0	6.00
7.00	Inventory	380,983	0	0	0	7.00
8.00	Prepaid expenses	115,051	0	0	0	8.00
9.00	Other current assets	292,563	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	5,268,265	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	140,146	0	0	0	12.00
13.00	Land improvements	66,241	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	1,721,296	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	6,198,477	0	0	0	19.00
20.00	Accumulated depreciation	-5,477,362	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)	2,648,798	0	0	0	30.00
<b>OTHER ASSETS</b>						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	28,284,762	-3,260	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	28,284,762	-3,260	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	36,201,825	-3,260	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	2,142,079	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,079,315	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	1,869,306	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	5,090,700	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	900,661	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	900,661	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	5,991,361	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	30,210,464				52.00
53.00	Specific purpose fund		-3,260			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	30,210,464	-3,260	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	36,201,825	-3,260	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151316

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

Worksheet G-1

Date/Time Prepared:  
1/26/2012 9:13 am

	General Fund		Special Purpose Fund		
	1:00	2:00	3:00	4:00	
1.00 Fund balances at beginning of period		20,142,734		33,108	1.00
2.00 Net income (loss) (from Wkst. G-3, line 29)		9,555,525			2.00
3.00 Total (sum of line 1 and line 2)		29,698,259		33,108	3.00
4.00 RESTRICTED CONTRIB. USED FOR PROPERT	51,876		0		4.00
5.00 DEFERRED PENSION COSTS	670,372		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)		722,248		0	10.00
11.00 Subtotal (line 3 plus line 10)		30,420,507		33,108	11.00
12.00 TRANSFERS TO AFFILIATES	1,427		0		12.00
13.00 UNRESTRICTED ACTIVITY	8,616		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)		10,043		0	18.00
19.00 Fund balance at end of period per balance sheet (line 11 minus line 18)		30,410,464		33,108	19.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151316

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

Worksheet G-1

Date/Time Prepared:  
1/26/2012 9:13 am

	Endowment Fund		Plant Fund			
	5.00	6.00	7.00	8.00		
1.00			0		0	1.00
2.00						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
11.00		0			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		0			0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 151316

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

Worksheet G-2 Parts

Date/Time Prepared:  
1/26/2012 9:13 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
<b>General Inpatient Routine Services</b>					
1.00	Hospital	5,724,702		5,724,702	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	5,724,702		5,724,702	10.00
<b>Intensive Care Type Inpatient Hospital Services</b>					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	5,724,702		5,724,702	17.00
18.00	Ancillary services	8,829,113	49,784,033	58,613,146	18.00
19.00	Outpatient services	0	322,071	322,071	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC		0	0	24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to wkst. G-3, line 1)	14,553,815	50,106,104	64,659,919	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per wkst. A, column 3, line 200)		21,894,567		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to wkst. G-3, line 4)		21,894,567		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 151316

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

Worksheet G-3

Date/Time Prepared:  
1/26/2012 9:13 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	64,659,919	1.00
2.00	Less contractual allowances and discounts on patients' accounts	32,346,802	2.00
3.00	Net patient revenues (line 1 minus line 2)	32,313,117	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	21,894,567	4.00
5.00	Net income from service to patients (line 3 minus line 4)	10,418,550	5.00
<b>OTHER INCOME</b>			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	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	149,052	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	16,919	17.00
18.00	Revenue from sale of medical records and abstracts	7,581	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	176,308	22.00
23.00	Governmental appropriations	0	23.00
24.00	NET ASSETS RELEASED FROM RESTRICTION	22,823	24.00
24.01	MISC	82,786	24.01
24.02	INTERCO. INTEREST - NON-OP.	4,065,160	24.02
25.00	Total other income (sum of lines 6-24)	4,520,629	25.00
26.00	Total (line 5 plus line 25)	14,939,179	26.00
27.00	BAD DEBT	5,383,654	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	5,383,654	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	9,555,525	29.00