

**ST. VINCENT JENNINGS HOSPITAL
NORTH VERNON, INDIANA**

PROVIDER NOS. 15-1303, 15-Z303 AND AIM NO. 200360180

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

JUNE 30, 2011

ST. VINCENT JENNINGS HOSPITAL
PROVIDER NOS. 15-1303, 15-Z303 AND AIM NO. 200360180

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Accountants' Disclaimer

Hospital Statements of Reimbursable Costs

Board of Directors
St. Vincent Jennings Hospital
North Vernon, Indiana

In accordance with your request, we have compiled the Hospital Statements of Reimbursable Costs (Titles XVIII and XIX) of St. Vincent Jennings Hospital (Provider Nos. 15-1303, 15-Z303 and AIM No. 200360180) 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.

Bailey Associates

January 27, 2012



Board of Directors
St. Vincent Jennings Hospital
North Vernon, Indiana

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Bradley Associates

January 27, 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: 151303 Period: From 07/01/2010 To 06/30/2011 worksheet 5 Parts I-III Date/Time Prepared: 1/27/2012 4:35 pm

PART I - COST REPORT STATUS

Provider use only 1. Electronically filed cost report Date: 1/27/2012 Time: 4:35 pm
 2. Manually submitted cost report
 3. If this is an amended report enter the number of times the provider resubmitted this cost report
 4. Medicare Utilization. Enter "F" for full or "L" for low.

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

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 JENNINGS 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: 4:35 pm
 95PELRQBvbrYlVht4:hag\lVitruxg0
 ZSMoi095.0DXvoIPPcPymdGk3o7ob1
 tcQv0PJgkN0AR0AE
 PI: Date: 1/27/2012 Time: 4:35 pm
 LL34GTqU83Xds7:2mRrTEd7rBTKPq0
 :a9JB0ZjwGrXH0NyMDXwh3Qob:P7yf
 HC4.TnE3mt0JR6GQ

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

Title _____

Date _____

	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	-224,972	-238,092	0	0	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
4.00 SUBPROVIDER I	0	0	0	0	0	4.00
5.00 Swing bed - SNF	0	-140,512	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
7.00 Skilled Nursing Facility	0	0	0	0	0	7.00
8.00 Nursing Facility	0	0	0	0	0	8.00
9.00 HOME HEALTH AGENCY I	0	0	0	0	0	9.00
10.00 RURAL HEALTH CLINIC I	0	0	0	0	0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0	0	0	0	0	11.00
12.00 CMHC I	0	0	0	0	0	12.00
200.00 Total	0	-365,484	-238,092	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: 151303	Period: From 07/01/2010 To 06/30/2011	Worksheet S-2 Part I Date/Time Prepared: 1/27/2012 9:36 am
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		1.00	2.00	3.00	4.00				
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 301 HENRY STREET	PO Box:						1.00	
2.00	City: NORTH VERNON	State: IN		Zip Code: 47265		County: JENNINGS		2.00	
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)		
							V	XVIII	XIX
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00
Hospital and Hospital-Based Component Identification:									
3.00	Hospital	ST. VINCENT JENNINGS HOSPITAL	151303	15	1	07/01/1996	N	O	O
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 JENNINGS SWING BED	152303	15		07/05/1991	N	O	N
8.00	Swing Beds - NF						N		N
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						N	N	N
14.00	Hospital-Based Hospice								14.00
15.00	Hospital-Based Health Clinic - RHC						N	N	N
16.00	Hospital-Based Health Clinic - FQHC								16.00
17.00	Hospital-Based (CMHC) 1								17.00
18.00	Renal Dialysis								18.00
19.00	Other								19.00
						From:	To:		
						1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)					07/01/2010	06/30/2011		20.00
21.00	Type of Control (see instructions)					2		21.00	
Inpatient PPS Information									
22.00	Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N		N	
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	
		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		
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		
						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	
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	
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	
						Beginning:	Ending:		
						1.00	2.00		
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00	

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151303	Period: From 07/01/2010 To 06/30/2011	Worksheet S-2 Part I Date/Time Prepared: 1/27/2012 9:36 am		
		Beginning: 1.00	Ending: 2.00			
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.		0		37.00	
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.				38.00	
		V 1.00	XVIII 2.00	XIX 3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00	
46.00	Is this facility eligible for the special exceptions payment pursuant to 42 CFR Section §412.348(g)? If yes, complete worksheet L, Part III and L-1, Parts I through III	N	N	N	46.00	
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N	47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00	
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete worksheet E-4. If column 2 is "N", complete worksheet D, Part III & IV and D-2, Part II, if applicable.				57.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete worksheet D-5.	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	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)		0.00		62.00	
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)		0.00		62.01	
Teaching Hospitals that Claim Residents in Non-Provider Settings						
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete lines 64-67. (see instructions)	N			63.00	
		Unweighted FTEs Nonprovider Site 1.00	Unweighted FTEs in Hospital 2.00	Ratio (col. 1/(col. 1 + col. 2)) 3.00		
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	64.00
		Program Name 1.00	Program Code 2.00	Unweighted FTEs Nonprovider Site 3.00	Unweighted FTEs in Hospital 4.00	Ratio (col. 3/(col. 3 + col. 4)) 5.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 151303

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

Worksheet S-2
Part I
Date/Time Prepared:
1/27/2012 9:36 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	Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010		0.00	0.00	0.000000	66.00
	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)					
	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	Inpatient Psychiatric Facility PPS 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
						1.00
75.00	Inpatient Rehabilitation Facility PPS 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	Long Term Care Hospital PPS 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: 151303	Period: From 07/01/2010 To 06/30/2011	Worksheet S-2 Part I Date/Time Prepared: 1/27/2012 9:36 am	
					1.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		N		86.00
					V 1.00
					XIX 2.00
Title V or XIX Inpatient Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.		N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.		N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.		N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.		N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.		N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	97.00
Rural Providers					
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?		Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)		N		106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)		N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(C). Enter "Y" for yes or "N" for no.		N		108.00
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	Y	Y	Y	N
					1.00
					2.00
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2.		N		115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.		N		116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.		Y		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.			1	118.00
119.00	What is the liability limit for the malpractice insurance policy? Enter in column 1 the monetary limit per lawsuit. Enter in column 2 the monetary limit per policy year.			1	119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 as amended by the Medicaid Extender Act (MMEA) §108? Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with ≤ 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121? Enter in column 2 "Y" for yes or "N" for no.		N	N	120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.		Y		121.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 151303 Period: From 07/01/2010 To 06/30/2011 Worksheet S-2 Part I Date/Time Prepared: 1/27/2012 9:36 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
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	15HO46	140.00
		1.00	2.00	3.00
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.				
141.00	Name: ST. VINCENT HEALTH	Contractor's Name: NATIONAL GOVERNMENT SERVICES		Contractor's Number: 00130
142.00	Street: 10330 N. MERIDAN ST	PO Box:		
143.00	City: INDIANAPOLIS	State: IN	Zip Code: 46290	
		1.00		
144.00	Are provider based physicians' costs included in worksheet A?		Y	144.00
145.00	If costs for renal services are claimed on worksheet A, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.		N	145.00
		1.00	2.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N		147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N		148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N		149.00
		Part A	Part B	
		1.00	2.00	
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)				
155.00	Hospital	N	N	155.00
156.00	Subprovider - IPF	N	N	156.00
157.00	Subprovider - IRF	N	N	157.00
158.00	Subprovider - Other	N	N	158.00
159.00	SNF	N	N	159.00
160.00	HHA	N	N	160.00
161.00	CMHC	N	N	161.00
		1.00		
165.00	Multicampus Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.		N	165.00
		Name	County	State
		0	1.00	2.00
		Zip Code	CBSA	FTE/Campus
		3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5			0.00
		1.00		
Health Information Technology (HIT) Incentive in the American Recovery and Reinvestment Act				
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.		N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)			0.00
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

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

		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
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)				
Capital Related Cost				
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	Y		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N		27.00
Interest Expense				
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	N		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N		31.00
Purchased Services				
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	Y		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.	Y		33.00
Provider-Based Physicians				
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	N		35.00
		Y/N	Date	
		1.00	2.00	
Home Office Costs				
36.00	Were home office costs claimed on the cost report?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151303

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

Worksheet S-3
Part I
Date/Time Prepared:
1/27/2012 9:36 am

Cost Center Description	Worksheet A	No. of Beds	Bed Days	CAH Hours	
	Line Number	2.00	3.00 Available	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	25,248.00	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	25,248.00	7.00
8.00 INTENSIVE CARE UNIT	31.00	0	0	0.00	8.00
9.00 CORONARY CARE UNIT					9.00
10.00 BURN INTENSIVE CARE UNIT					10.00
11.00 SURGICAL INTENSIVE CARE UNIT					11.00
12.00 OTHER SPECIAL CARE (SPECIFY)					12.00
13.00 NURSERY					13.00
14.00 Total (see instructions)		25	9,125	25,248.00	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.)	115.00				23.00
24.00 HOSPICE	116.00	0	0		24.00
25.00 CMHC - CMHC					25.00
26.00 RURAL HEALTH CLINIC	88.00				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

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	675	76	1,052	1.00	
2.00 HMO		5	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	580	0	580	5.00	
6.00 Hospital Adults & Peds. Swing Bed NF	0		0	51	6.00	
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	0	1,255	76	1,683	7.00	
8.00 INTENSIVE CARE UNIT	0	0	0	0	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	1,255	76	1,683	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		0	0	0	24.00	
25.00 CMHC - CMHC					25.00	
26.00 RURAL HEALTH CLINIC	0	0	0	0	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	251	28.00	
29.00 Ambulance Trips		0			29.00	
30.00 Employee discount days (see instruction)				3	30.00	
31.00 Employee discount days - IRF				0	31.00	
32.00 Labor & delivery days (see instructions)			0	0	32.00	
33.00 LTCH non-covered days		0			33.00	

Cost Center Description	Full Time Equivalents			Discharges		
	Total Interns & Residents	Employees On Payroll	Nonpaid workers	Title V	Title XVIII	
	9.00	10.00	11.00	12.00	13.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)				0	227	1.00
2.00 HMO					1	2.00
3.00 HMO IPF						3.00
4.00 HMO IRF						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	135.68	0.00	0	227	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.)	0.00	0.00	0.00			23.00
24.00 HOSPICE	0.00	0.00	0.00			24.00
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0.00	0.00	0.00			26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)	0.00	135.68	0.00			27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

Cost Center Description	Discharges		
	Title XIX	Total All Patients	
	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	24	422	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)	24	422	14.00
15.00 CAH visits			15.00
16.00 SUBPROVIDER - IPF			16.00
17.00 SUBPROVIDER - IRF			17.00
18.00 SUBPROVIDER			18.00
19.00 SKILLED NURSING FACILITY			19.00
20.00 NURSING FACILITY			20.00
21.00 OTHER LONG TERM CARE			21.00
22.00 HOME HEALTH AGENCY			22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)			23.00
24.00 HOSPICE			24.00
25.00 CMHC - CMHC			25.00
26.00 RURAL HEALTH CLINIC			26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER			26.25
27.00 Total (sum of lines 14-26)			27.00
28.00 Observation Bed Days			28.00
29.00 Ambulance Trips			29.00
30.00 Employee discount days (see instruction)			30.00
31.00 Employee discount days - IRF			31.00
32.00 Labor & delivery days (see instructions)			32.00
33.00 LTCH non-covered days			33.00

		1.00			
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 200 column 3 divided by line 200 column 8)	0.352160			1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid	975,760			2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N			3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?				4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0			5.00
6.00	Medicaid charges	8,894,806			6.00
7.00	Medicaid cost (line 1 times line 6)	3,132,395			7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	2,156,635			8.00
State Children's Health Insurance Program (SCHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone SCHIP	0			9.00
10.00	Stand-alone SCHIP charges	0			10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0			11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0			12.00
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0			13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0			14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0			15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0			16.00
Uncompensated care (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care	0			17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	223,764			18.00
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	2,156,635			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	3,872,885	5,213	3,878,098	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	1,363,875	1,836	1,365,711	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,363,875	1,836	1,365,711	23.00
1.00					
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N			24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0			25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	4,757,491			26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	496,924			27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)	4,260,567			28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)	1,500,401			29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)	2,866,112			30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	5,022,747			31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151303

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

Worksheet A

Date/Time Prepared:
1/27/2012 9:36 am

Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
	1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS						
1.00		828,303	828,303	-113,183	715,120	1.00
2.00		0	0	0	0	2.00
3.00		0	0	0	0	3.00
4.00	162,955	2,117,565	2,280,520	-1,012	2,279,508	4.00
5.00	1,790,274	1,939,420	3,729,694	112,367	3,842,061	5.00
6.00	0	0	0	0	0	6.00
7.00	145,110	731,322	876,432	-361	876,071	7.00
8.00	0	110,039	110,039	0	110,039	8.00
9.00	233,115	78,818	311,933	-1,235	310,698	9.00
10.00	121,632	70,646	192,278	-139,021	53,257	10.00
11.00	0	0	0	138,517	138,517	11.00
12.00	0	0	0	0	0	12.00
13.00	220,544	41,477	262,021	0	262,021	13.00
14.00	69,509	11,722	81,231	-12	81,219	14.00
15.00	166,352	389,487	555,839	-91	555,748	15.00
16.00	154,693	26,569	181,262	-48	181,214	16.00
17.00	0	0	0	0	0	17.00
18.00	0	0	0	0	0	18.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	929,141	305,245	1,234,386	-33,967	1,200,419	30.00
31.00	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS						
50.00	412,299	404,394	816,693	-39,136	777,557	50.00
51.00	0	0	0	0	0	51.00
52.00	0	0	0	0	0	52.00
53.00	0	0	0	0	0	53.00
54.00	780,663	996,044	1,776,707	-25,030	1,751,677	54.00
55.00	0	0	0	0	0	55.00
56.00	0	0	0	0	0	56.00
57.00	0	0	0	0	0	57.00
58.00	0	0	0	0	0	58.00
59.00	0	0	0	0	0	59.00
60.00	32,433	1,399,961	1,432,394	-18,365	1,414,029	60.00
60.01	0	0	0	0	0	60.01
61.00	0	0	0	0	0	61.00
62.00	0	0	0	0	0	62.00
63.00	0	0	0	0	0	63.00
64.00	0	0	0	0	0	64.00
65.00	0	21,837	21,837	-3,585	18,252	65.00
66.00	0	246,974	246,974	-3,341	243,633	66.00
67.00	0	23,166	23,166	0	23,166	67.00
68.00	0	-4,818	-4,818	0	-4,818	68.00
69.00	0	23,610	23,610	19,991	43,601	69.00
70.00	0	0	0	0	0	70.00
71.00	0	197,450	197,450	162,597	360,047	71.00
72.00	0	101,902	101,902	0	101,902	72.00
73.00	0	0	0	0	0	73.00
74.00	0	0	0	0	0	74.00
75.00	0	0	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS						
88.00	0	868	868	0	868	88.00
91.00	909,641	1,442,504	2,352,145	-55,085	2,297,060	91.00
92.00	0	0	0	0	0	92.00
93.00	0	0	0	0	0	93.00
SPECIAL PURPOSE COST CENTERS						
115.00	0	0	0	0	0	115.00
116.00	0	0	0	0	0	116.00
118.00	6,128,361	11,504,505	17,632,866	0	17,632,866	118.00
NONREIMBURSABLE COST CENTERS						
190.00	0	0	0	0	0	190.00
191.00	0	0	0	0	0	191.00
192.00	0	0	0	0	0	192.00
193.00	0	0	0	0	0	193.00
194.00	132,625	27,230	159,855	0	159,855	194.00
194.01	0	0	0	0	0	194.01
194.02	9,423	844	10,267	0	10,267	194.02
194.03	0	0	0	0	0	194.03
194.04	0	0	0	0	0	194.04
200.00	6,270,409	11,532,579	17,802,988	0	17,802,988	200.00

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RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151303

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

Worksheet A

Date/Time Prepared:
1/27/2012 9:36 am

Cost Center Description		Adjustments (See A-8) 6:00	Net Expenses For Allocation 7:00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	-124,003	591,117	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	2.00
3.00	OTHER CAP RELATED COST	0	0	3.00
4.00	EMPLOYEE BENEFITS	-45,529	2,233,979	4.00
5.00	ADMINISTRATIVE & GENERAL	-120,717	3,721,344	5.00
6.00	MAINTENANCE & REPAIRS	0	0	6.00
7.00	OPERATION OF PLANT	-15,566	860,505	7.00
8.00	LAUNDRY & LINEN SERVICE	0	110,039	8.00
9.00	HOUSEKEEPING	58,496	369,194	9.00
10.00	DIETARY	-46,736	6,521	10.00
11.00	CAFETERIA	0	138,517	11.00
12.00	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	NURSING ADMINISTRATION	0	262,021	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	81,219	14.00
15.00	PHARMACY	-6,220	549,528	15.00
16.00	MEDICAL RECORDS & LIBRARY	-11,510	169,704	16.00
17.00	SOCIAL SERVICE	0	0	17.00
18.00	OTHER GENERAL SERVICE (SPECIFY)	0	0	18.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	-147,869	1,052,550	30.00
31.00	INTENSIVE CARE UNIT	0	0	31.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	-50,875	726,682	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	-8,608	1,743,069	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	-452	1,413,577	60.00
60.01	BLOOD LABORATORY	0	0	60.01
61.00	PBP CLINICAL LAB. SERVICE-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	18,252	65.00
66.00	PHYSICAL THERAPY	-67,050	176,583	66.00
67.00	OCCUPATIONAL THERAPY	0	23,166	67.00
68.00	SPEECH PATHOLOGY	7,391	2,573	68.00
69.00	ELECTROCARDIOLOGY	-22,000	21,601	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	360,047	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	101,902	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
OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	-868	0	88.00
91.00	EMERGENCY	-509,855	1,787,205	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
93.00	FAMILY PRACTICE	0	0	93.00
SPECIAL PURPOSE COST CENTERS				
115.00	AMBULATORY SURGICAL CENTER (D.P.)	0	0	115.00
116.00	HOSPICE	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	-1,111,971	16,520,895	118.00
NONREIMBURSABLE COST CENTERS				
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 COST CENTERS	0	159,855	194.00
194.01	TOBACCO / CHILD GRANT	0	0	194.01
194.02	OUTPATIENT CLINICS	0	10,267	194.02
194.03	OTHER NONREIMBURSABLE COST CENTERS	217,084	217,084	194.03
194.04	SPN	0	0	194.04
200.00	TOTAL (SUM OF LINES 118-199)	-894,887	16,908,101	200.00

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		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
A - CAFETERIA					
1.00	CAFETERIA	11.00	87,624	50,893	1.00
	TOTALS		87,624	50,893	
B - INTEREST					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	113,183	1.00
	TOTALS		0	113,183	
C - ELECTROCARDIOLOGY					
1.00	ELECTROCARDIOLOGY	69.00	19,991	0	1.00
	TOTALS		19,991	0	
D - MEDICAL SUPPLIES CHARGED TO PATIENTS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	162,597	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
	TOTALS		0	162,597	
500.00	Grand Total: Increases		107,615	326,673	500.00

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - CAFETERIA							
1.00	DIETARY	10.00	87,624	50,893	0		1.00
	TOTALS		87,624	50,893			
B - INTEREST							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	113,183	9		1.00
	TOTALS		0	113,183			
C - ELECTROCARDIOLOGY							
1.00	LABORATORY	60.00	19,991	0	0		1.00
	TOTALS		19,991	0			
D - MEDICAL SUPPLIES CHARGED TO PATIENTS							
1.00	EMPLOYEE BENEFITS	4.00	0	1,012	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	816	0		2.00
3.00	OPERATION OF PLANT	7.00	0	361	0		3.00
4.00	HOUSEKEEPING	9.00	0	1,235	0		4.00
5.00	DIETARY	10.00	0	504	0		5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	12	0		6.00
7.00	PHARMACY	15.00	0	91	0		7.00
8.00	MEDICAL RECORDS & LIBRARY	16.00	0	48	0		8.00
9.00	ADULTS & PEDIATRICS	30.00	0	33,967	0		9.00
10.00	OPERATING ROOM	50.00	0	39,136	0		10.00
11.00	RADIOLOGY - DIAGNOSTIC	54.00	0	25,030	0		11.00
12.00	LABORATORY	60.00	0	-1,626	0		12.00
13.00	RESPIRATORY THERAPY	65.00	0	3,585	0		13.00
14.00	PHYSICAL THERAPY	66.00	0	3,341	0		14.00
15.00	EMERGENCY	91.00	0	55,085	0		15.00
	TOTALS		0	162,597			
500.00	Grand Total: Decreases		107,615	326,673			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151303

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
1/27/2012 9:36 am

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	127,944	0	0	0	1.00
2.00	Land Improvements	400,829	0	0	0	2.00
3.00	Buildings and Fixtures	13,498,332	47,352	0	47,352	3.00
4.00	Building Improvements	0	0	0	0	4.00
5.00	Fixed Equipment	4,108,719	0	0	0	5.00
6.00	Movable Equipment	0	0	0	0	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	18,135,824	47,352	0	47,352	8.00
9.00	Reconciling Items	0	47,352	0	47,352	9.00
10.00	Total (line 8 minus line 9)	18,135,824	0	0	0	10.00
SUMMARY OF CAPITAL						
Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
	9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	828,303	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	828,303	0	0	0	3.00
COMPUTATION OF RATIOS						
Cost Center Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL Ratio (see instructions)	Insurance	
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	18,052,400	0	18,052,400	1.000000	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	2.00
3.00	Total (sum of lines 1-2)	18,052,400	0	18,052,400	1.000000	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151303

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
1/27/2012 9:36 am

		Ending Balance	Fully Depreciated Assets			
		6.00	7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	127,944	0		1.00	
2.00	Land Improvements	400,829	0		2.00	
3.00	Buildings and Fixtures	13,545,341	0		3.00	
4.00	Building Improvements	0	0		4.00	
5.00	Fixed Equipment	4,025,638	0		5.00	
6.00	Movable Equipment	0	0		6.00	
7.00	HIT designated Assets	0	0		7.00	
8.00	Subtotal (sum of lines 1-7)	18,099,752	0		8.00	
9.00	Reconciling Items	47,352	0		9.00	
10.00	Total (line 8 minus line 9)	18,052,400	0		10.00	
SUMMARY OF CAPITAL						
Cost Center Description		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)			
		14.00	15.00			
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	828,303		1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		2.00	
3.00	Total (sum of lines 1-2)	0	828,303		3.00	
ALLOCATION OF OTHER CAPITAL						
Cost Center Description		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL Depreciation	Lease
		6.00	7.00	8.00	9.00	10.00
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	591,117	0
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0
3.00	Total (sum of lines 1-2)	0	0	0	591,117	0

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151303

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
1/27/2012 9:36 am

Cost Center Description	SUMMARY OF CAPITAL					Total (2) (sum of cols. 9 through 14)	
	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
	11.00	12.00	13.00	14.00	15.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	591,117	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	591,117	3.00

	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From which the Amount is to be Adjusted	
			Cost Center	Line #
	1.00	2.00	3.00	4.00
1.00 Investment income - buildings and fixtures (chapter 2)	A	-102,660	CAP REL COSTS-BLDG & FIXT	1.00 1.00
2.00 Investment income - movable equipment (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00 2.00
3.00 Investment income - other (chapter 2)	A	-37,982	ADMINISTRATIVE & GENERAL	5.00 3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0		0.00 4.00
5.00 Refunds and rebates of expenses (chapter 8)		0		0.00 5.00
6.00 Rental of provider space by suppliers (chapter 8)		0		0.00 6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0		0.00 7.00
8.00 Television and radio service (chapter 21)	A	-5,049	OPERATION OF PLANT	7.00 8.00
9.00 Parking lot (chapter 21)		0		0.00 9.00
10.00 Provider-based physician adjustment	A-8-2	-739,207		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	71,978		12.00
13.00 Laundry and linen service		0		0.00 13.00
14.00 Cafeteria-employees and guests	B	-25,330	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		0		0.00 17.00
18.00 Sale of medical records and abstracts	B	-11,510	MEDICAL RECORDS & LIBRARY	16.00 18.00
19.00 Nursing school (tuition, fees, books, etc.)		0		0.00 19.00
20.00 Vending machines	B	-1,546	ADMINISTRATIVE & GENERAL	5.00 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	-67,050	PHYSICAL THERAPY	66.00 24.00
25.00 Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00 25.00
26.00 Depreciation - buildings and fixtures		0	CAP REL COSTS-BLDG & FIXT	1.00 26.00
27.00 Depreciation - movable equipment		0	CAP REL COSTS-MVBLE EQUIP	2.00 27.00
28.00 Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00 28.00
29.00 Physicians' assistant		0		0.00 29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00 30.00
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00 31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0		0.00 32.00
33.00 REVERSE PRIOR YEAR SPEECH THER. ADJ	A	7,391	SPEECH PATHOLOGY	68.00 33.00
33.01 MISC REVENUE	B	-5,758	EMPLOYEE BENEFITS	4.00 33.01
33.02 MISC REVENUE	B	-3,984	ADMINISTRATIVE & GENERAL	5.00 33.02
33.03 MISC REVENUE	B	-21,406	DIETARY	10.00 33.03
33.04 MISC REVENUE	B	-226	PHARMACY	15.00 33.04
33.05 MISC REVENUE	B	-452	LABORATORY	60.00 33.05
33.06 RHC DEPRECIATION	A	-868	RURAL HEALTH CLINIC	88.00 33.06
33.07 SPN HOUSEKEEPING	A	74,093	HOUSEKEEPING	9.00 33.07
33.08 PHYSICIAN HOUSEKEEPING	A	-15,597	HOUSEKEEPING	9.00 33.08
33.09 PHYSICIAN PLANT OPS	A	-10,517	OPERATION OF PLANT	7.00 33.09
33.10 PHYSICIAN BENEFITS	A	-4,043	EMPLOYEE BENEFITS	4.00 33.10
33.11 PATIENT PHONE BENEFITS	A	-743	EMPLOYEE BENEFITS	4.00 33.11
33.12 PATIENT PHONE DEPRECIATION	A	-427	CAP REL COSTS-BLDG & FIXT	1.00 33.12
33.13 PATIENT PHONE OPERATING COSTS	A	-2,442	ADMINISTRATIVE & GENERAL	5.00 33.13
33.14 ADVERTISING EXPENSE	A	-154	ADMINISTRATIVE & GENERAL	5.00 33.14
33.15 ADVERTISING EXPENSE	A	-550	EMPLOYEE BENEFITS	4.00 33.15
33.16 AHA & IHA DUES	A	-896	ADMINISTRATIVE & GENERAL	5.00 33.16
33.17 PAYROLL INCENTIVE	A	2,050	ADMINISTRATIVE & GENERAL	5.00 33.17
33.18 SERVICING FEES	A	20,670	ADMINISTRATIVE & GENERAL	5.00 33.18
33.19 CHARITABLE EXPENSE	A	-45	EMPLOYEE BENEFITS	4.00 33.19
33.20 CHARITABLE EXPENSE	A	-6,633	ADMINISTRATIVE & GENERAL	5.00 33.20
33.21 CHARITABLE EXPENSE	A	-5,994	PHARMACY	15.00 33.21

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Provider CCN: 151303

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

Worksheet A-8

Date/Time Prepared:
 1/27/2012 9:36 am

				Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted	
		Basis/Code (2)	Amount	Cost Center	Line #
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200.)	1.00	-894,887	3.00	4.00
					50.00

		Wkst. A-7 Ref.	
		5.00	
1.00	Investment income - buildings and fixtures (chapter 2)	9	1.00
2.00	Investment income - movable equipment (chapter 2)	0	2.00
3.00	Investment income - other (chapter 2)	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	0	7.00
8.00	Television and radio service (chapter 21)	0	8.00
9.00	Parking lot (chapter 21)	0	9.00
10.00	Provider-based physician adjustment	0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	0	11.00
12.00	Related organization transactions (chapter 10)	0	12.00
13.00	Laundry and linen service	0	13.00
14.00	Cafeteria-employees and guests	0	14.00
15.00	Rental of quarters to employee and others	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	0	16.00
17.00	Sale of drugs to other than patients	0	17.00
18.00	Sale of medical records and abstracts	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)	0	19.00
20.00	Vending machines	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		25.00
26.00	Depreciation - buildings and fixtures	0	26.00
27.00	Depreciation - movable equipment	0	27.00
28.00	Non-physician Anesthetist		28.00
29.00	Physicians' assistant	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)		30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	0	32.00
33.00	REVERSE PRIOR YEAR SPEECH THER. ADJ	0	33.00
33.01	MISC REVENUE	0	33.01
33.02	MISC REVENUE	0	33.02
33.03	MISC REVENUE	0	33.03
33.04	MISC REVENUE	0	33.04
33.05	MISC REVENUE	0	33.05
33.06	RHC DEPRECIATION	0	33.06
33.07	SPN HOUSEKEEPING	0	33.07
33.08	PHYSICIAN HOUSEKEEPING	0	33.08
33.09	PHYSICIAN PLANT OPS	0	33.09
33.10	PHYSICIAN BENEFITS	0	33.10
33.11	PATIENT PHONE BENEFITS	0	33.11
33.12	PATIENT PHONE DEPRECIATION	9	33.12
33.13	PATIENT PHONE OPERATING COSTS	0	33.13
33.14	ADVERTISING EXPENSE	0	33.14
33.15	ADVERTISING EXPENSE	0	33.15
33.16	AHA & IHA DUES	0	33.16
33.17	PAYROLL INCENTIVE	0	33.17
33.18	SERVICING FEES	0	33.18
33.19	CHARITABLE EXPENSE	0	33.19
33.20	CHARITABLE EXPENSE	0	33.20
33.21	CHARITABLE EXPENSE	0	33.21
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: 151303

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

Worksheet A-8-1

Date/Time Prepared:
1/27/2012 9:36 am

	Line No.		Cost Center		Expense Items	
	1.00	2.00	3.00			
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE			1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE			2.00
3.00	194.03	OTHER NONREIMBURSABLE COST CENTERS	HOME OFFICE			3.00
4.00	1.00	CAP REL COSTS-BLDG & FIXT	ASCENSION - INTEREST			4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	ASCENSION - INTEREST			4.01
4.02	4.00	EMPLOYEE BENEFITS	ASCENSION - PENSION			4.02
4.03	1.00	CAP REL COSTS-BLDG & FIXT	ASCENSION - CHARGEBACK			4.03
4.04	5.00	ADMINISTRATIVE & GENERAL	ASCENSION - CHARGEBACK			4.04
4.05	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE - TRIMEDX			4.05
4.06	5.00	ADMINISTRATIVE & GENERAL	ST. VINCENT HEALTH - CHAR			4.06
4.07	7.00	OPERATION OF PLANT	ST. VINCENT HEALTH - CHAR			4.07
4.08	14.00	CENTRAL SERVICES & SUPPLY	ST. VINCENT HEALTH - CHAR			4.08
4.09	16.00	MEDICAL RECORDS & LIBRARY	ST. VINCENT HEALTH - CHAR			4.09
4.10	54.00	RADIOLOGY - DIAGNOSTIC	ST. VINCENT HEALTH - CHAR			4.10
4.11	60.00	LABORATORY	ST. VINCENT HEALTH - CHAR			4.11
4.12	91.00	EMERGENCY	ST. VINCENT HEALTH - CHAR			4.12
4.13	4.00	EMPLOYEE BENEFITS	ST. VINCENT HEALTH - CHAR			4.13
4.14	4.00	EMPLOYEE BENEFITS	SELF INSURANCE			4.14
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to worksheet A-8, column 2, line 12.					5.00

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

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

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

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

6.00	G	ST. VINCENT HEA	100.00	6.00
7.00	B	ASCENSION	100.00	7.00
8.00	B	ST. VINCENT HOS	100.00	8.00
9.00			0.00	9.00
10.00			0.00	10.00
100.00	G. Other (financial or non-financial) specify:	HOME OFFICE		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	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	182,338	0	182,338	9	1.00
2.00	1,489,341	1,484,258	5,083	0	2.00
3.00	217,084	0	217,084	0	3.00
4.00	102,660	305,914	-203,254	9	4.00
4.01	37,982	113,183	-75,201	0	4.01
4.02	386,520	386,520	0	0	4.02
4.03	10,659	10,659	0	9	4.03
4.04	32,056	32,056	0	0	4.04
4.05	263,103	282,785	-19,682	0	4.05
4.06	1,079,056	1,079,056	0	0	4.06
4.07	110,125	110,125	0	0	4.07
4.08	9,048	9,048	0	0	4.08
4.09	56,359	56,359	0	0	4.09
4.10	15,407	15,407	0	0	4.10
4.11	10,800	10,800	0	0	4.11
4.12	43,200	43,200	0	0	4.12
4.13	276,356	276,356	0	0	4.13
4.14	753,093	787,483	-34,390	0	4.14
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to worksheet A-8, column 2, line 12.	5,075,187	5,003,209	71,978	5.00

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

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151303

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

Worksheet A-8-2

Date/Time Prepared:
1/27/2012 9:36 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
	1.00	2.00	3.00	4.00	
1.00	30.00	ADULTS & PEDIATRICS	147,869	147,869	1.00
2.00	50.00	OPERATING ROOM	50,875	50,875	2.00
3.00	54.00	RADIOLOGY - DIAGNOSTIC	8,608	8,608	3.00
4.00	69.00	ELECTROCARDIOLOGY	22,000	22,000	4.00
5.00	91.00	ER PHYSICIAN	1,265,050	509,855	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)	1,494,402	739,207	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151303

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

Worksheet A-8-2
Date/Time Prepared:
1/27/2012 9:36 am

	Provider Component	RCE Amount	Physician/Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	5.00	6.00	7.00	8.00	9.00	
1.00	0	0	0	0	0	1.00
2.00	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	755,195	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	755,195		0	0	0	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151303

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

Worksheet A-8-2

Date/Time Prepared:
1/27/2012 9:36 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: 151303

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

Worksheet A-8-2

Date/Time Prepared:
1/27/2012 9:36 am

	RCE Disallowance	Adjustment	
	17.00	18.00	
1.00	0	147,869	1.00
2.00	0	50,875	2.00
3.00	0	8,608	3.00
4.00	0	22,000	4.00
5.00	0	509,855	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	739,207	200.00

		Physical Therapy					Cost	
							1.00	
PART I - GENERAL INFORMATION								
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)					142	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)					113	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					5.61	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	305.00	2,505.00	0.00	0.00	9.00	
10.00	AHSEA (see instructions)	0.00	70.79	55.54	0.00	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)	35.40	35.40	27.77			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	
Part II - SALARY EQUIVALENCY COMPUTATION								
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)					21,591	15.00	
16.00	Assistants (column 3, line 9 times column 3, line 10)					139,128	16.00	
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					160,719	17.00	
18.00	Aides (column 4, line 9 times column 4, line 10)					0	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)					160,719	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)					160,719	23.00	
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE								
Standard Travel Allowance								
24.00	Therapists (line 3 times column 2, line 11)					5,027	24.00	
25.00	Assistants (line 4 times column 3, line 11)					3,138	25.00	
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					8,165	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)					1,431	27.00	
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					9,596	28.00	
Optional Travel Allowance and Optional Travel Expense								
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)					9,596	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	
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE								
Standard Travel Expense								
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	
Optional Travel Allowance and Optional Travel Expense								
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	
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.								
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: 151303

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

Worksheet A-8-3 Par

Date/Time Prepared: 1/27/2012 9:36 am

		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	
PART V - OVERTIME COMPUTATION							
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
CALCULATION OF LIMIT							
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
DETERMINATION OF OVERTIME ALLOWANCE							
52.00	Adjusted hourly salary equivalency amount (see instructions)	70.79	55.54	0.00	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	
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT							
57.00	Salary equivalency amount (from line 23)					160,719	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35)					9,596	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)					170,315	63.00
64.00	Total cost of outside supplier services (from your records)					237,365	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)					67,050	65.00
LINE 33 CALCULATION							
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others					8,165	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					1,431	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27					9,596	100.02
LINE 34 CALCULATION							
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					1,431	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					1,431	101.02
LINE 35 CALCULATION							
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

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY PROVIDER CCN: 151303 Period: From 07/01/2010 To 06/30/2011 Worksheet A-8-3 Par
 OUTSIDE SUPPLIERS Date/Time Prepared: 1/27/2012 9:36 am

		Occupational Therapy		Cost		
				1.00		
PART I - GENERAL INFORMATION						
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)			97	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)			45	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			5.61	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	198.00	87.00	0.00	0.00
10.00	AHSEA (see instructions)	0.00	67.11	52.65	0.00	0.00
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)	33.56	33.56	26.33		
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		
Part II - SALARY EQUIVALENCY COMPUTATION						
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)			13,288	15.00	
16.00	Assistants (column 3, line 9 times column 3, line 10)			4,581	16.00	
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)			17,869	17.00	
18.00	Aides (column 4, line 9 times column 4, line 10)			0	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)			17,869	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)			62.70	21.00	
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)			48,906	22.00	
23.00	Total salary equivalency (see instructions)			48,906	23.00	
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)			3,255	24.00	
25.00	Assistants (line 4 times column 3, line 11)			1,185	25.00	
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)			4,440	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)			797	27.00	
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)			5,237	28.00	
Optional Travel Allowance and Optional Travel Expense						
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)			5,237	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	
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
Standard Travel Expense						
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	
Optional Travel Allowance and Optional Travel Expense						
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	
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)			0	44.00	

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

Provider CCN: 151303

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

Worksheet A-8-3 Par

Date/Time Prepared: 1/27/2012 9:36 am

		Occupational Therapy				Cost	
						1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00
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	
PART V - OVERTIME COMPUTATION							
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
CALCULATION OF LIMIT							
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
DETERMINATION OF OVERTIME ALLOWANCE							
52.00	Adjusted hourly salary equivalency amount (see instructions)	67.11	52.65	0.00	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	
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT							
57.00	Salary equivalency amount (from line 23)					48,906	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					5,237	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)					54,143	63.00
64.00	Total cost of outside supplier services (from your records)					25,483	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)					0	65.00
LINE 33 CALCULATION							
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others					4,440	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					797	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27					5,237	100.02
LINE 34 CALCULATION							
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					797	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					797	101.02
LINE 35 CALCULATION							
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

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 151303	Period: From 07/01/2010 To 06/30/2011	Worksheet A-8-3 Par Date/Time Prepared: 1/27/2012 9:36 am
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		Speech Pathology					Cost	
							1.00	
PART I - GENERAL INFORMATION								
1.00	Total number of weeks worked (excluding aides) (see instructions)					21	1.00	
2.00	Line 1 multiplied by 15 hours per week					315	2.00	
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					23	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)					0	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					5.61	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	29.00	0.00	0.00	0.00	9.00	
10.00	AHSEA (see instructions)	0.00	64.50	0.00	0.00	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)	32.25	32.25	0.00			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	
Part II - SALARY EQUIVALENCY COMPUTATION								
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)					1,871	15.00	
16.00	Assistants (column 3, line 9 times column 3, line 10)					0	16.00	
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					1,871	17.00	
18.00	Aides (column 4, line 9 times column 4, line 10)					0	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)					1,871	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)					64.52	21.00	
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					20,324	22.00	
23.00	Total salary equivalency (see instructions)					20,324	23.00	
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE								
Standard Travel Allowance								
24.00	Therapists (line 3 times column 2, line 11)					742	24.00	
25.00	Assistants (line 4 times column 3, line 11)					0	25.00	
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					742	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)					129	27.00	
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					871	28.00	
Optional Travel Allowance and Optional Travel Expense								
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)					871	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	
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE								
Standard Travel Expense								
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	
Optional Travel Allowance and Optional Travel Expense								
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	
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.								
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: 151303

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

Worksheet A-8-3 Par

Date/Time Prepared:
1/27/2012 9:36 am

		Speech Pathology				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	
PART V - OVERTIME COMPUTATION							
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
CALCULATION OF LIMIT							
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
DETERMINATION OF OVERTIME ALLOWANCE							
52.00	Adjusted hourly salary equivalency amount (see instructions)	64.50	0.00	0.00	0.00	0.00	52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0	0	53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	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	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	
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT							
57.00	Salary equivalency amount (from line 23)					20,324	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					871	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)					21,195	63.00
64.00	Total cost of outside supplier services (from your records)					2,967	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)					0	65.00
LINE 33 CALCULATION							
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others					742	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					129	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27					871	100.02
LINE 34 CALCULATION							
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					129	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					129	101.02
LINE 35 CALCULATION							
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 ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151303

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

Worksheet B
Part I
Date/Time Prepared:
1/27/2012 9:36 am

Cost Center Description	Net Expenses for Cost Allocation (from wkst. A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	591,117	591,117			1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0		0		2.00
4.00	EMPLOYEE BENEFITS	2,233,979			2,233,979	4.00
5.00	ADMINISTRATIVE & GENERAL	3,721,344	52,222	0	654,847	4,428,413
6.00	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	OPERATION OF PLANT	860,505	53,962	0	53,078	967,545
8.00	LAUNDRY & LINEN SERVICE	110,039	642	0	0	110,681
9.00	HOUSEKEEPING	369,194	12,132	0	85,269	466,595
10.00	DIETARY	6,521	5,982	0	12,439	24,942
11.00	CAFETERIA	138,517	12,327	0	32,051	182,895
12.00	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	NURSING ADMINISTRATION	262,021	1,402	0	80,670	344,093
14.00	CENTRAL SERVICES & SUPPLY	81,219	9,834	0	25,425	116,478
15.00	PHARMACY	549,528	5,534	0	60,848	615,910
16.00	MEDICAL RECORDS & LIBRARY	169,704	46,815	0	56,583	273,102
17.00	SOCIAL SERVICE	0	0	0	0	17.00
18.00	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	18.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,052,550	55,458	0	339,860	1,447,868
31.00	INTENSIVE CARE UNIT	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	726,682	44,069	0	150,810	921,561
51.00	RECOVERY ROOM	0	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	RADIOLOGY - DIAGNOSTIC	1,743,069	35,713	0	285,550	2,064,332
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	1,413,577	13,214	0	4,551	1,431,342
60.01	BLOOD LABORATORY	0	0	0	0	60.01
61.00	PBP CLINICAL LAB. SERVICE-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	18,252	0	0	0	18,252
66.00	PHYSICAL THERAPY	176,583	14,295	0	0	190,878
67.00	OCCUPATIONAL THERAPY	23,166	0	0	0	23,166
68.00	SPEECH PATHOLOGY	2,573	0	0	0	2,573
69.00	ELECTROCARDIOLOGY	21,601	1,681	0	7,312	30,594
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	360,047	0	0	0	360,047
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	101,902	0	0	0	101,902
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
OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	0	0	88.00
91.00	EMERGENCY	1,787,205	35,671	0	332,728	2,155,604
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
93.00	FAMILY PRACTICE	0	0	0	0	93.00
SPECIAL PURPOSE COST CENTERS						
115.00	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	115.00
116.00	HOSPICE	0	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	16,520,895	400,953	0	2,182,021	16,278,773
NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	3,058	0	0	3,058
191.00	RESEARCH	0	0	0	0	191.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	6,683	0	0	6,683
193.00	NONPAID WORKERS	0	0	0	0	193.00
194.00	OTHER NONREIMBURSABLE COST CENTERS	159,855	0	0	48,511	208,366
194.01	TOBACCO / CHILD GRANT	0	0	0	0	194.01
194.02	OUTPATIENT CLINICS	10,267	62,859	0	3,447	76,573
194.03	OTHER NONREIMBURSABLE COST CENTERS	217,084	0	0	0	217,084
194.04	SPN	0	117,564	0	0	117,564
200.00	Cross Foot Adjustments					0

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COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151303

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

Worksheet B
Part I
Date/Time Prepared:
1/27/2012 9:36 am

Cost Center Description	Net Expenses for Cost Allocation (from wkst. A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
201.00 Negative Cost Centers	0	1.00	2.00	4.00	4A	0
202.00 TOTAL (sum lines 118-201)	16,908,101	591,117	0	2,233,979	16,908,101	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151303

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

Worksheet B
Part I
Date/Time Prepared:
1/27/2012 9:36 am

Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL	4,428,413					5.00
6.00	MAINTENANCE & REPAIRS	0	0				6.00
7.00	OPERATION OF PLANT	343,333	0	1,310,878			7.00
8.00	LAUNDRY & LINEN SERVICE	39,275	0	1,736	151,692		8.00
9.00	HOUSEKEEPING	165,571	0	32,797	40,122	705,085	9.00
10.00	DIETARY	8,851	0	16,170	4,218	28,434	10.00
11.00	CAFETERIA	64,900	0	33,322	0	0	11.00
12.00	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	NURSING ADMINISTRATION	122,101	0	3,791	0	0	13.00
14.00	CENTRAL SERVICES & SUPPLY	41,332	0	26,584	0	0	14.00
15.00	PHARMACY	218,556	0	14,959	0	5,077	15.00
16.00	MEDICAL RECORDS & LIBRARY	96,910	0	126,550	0	3,385	16.00
17.00	SOCIAL SERVICE	0	0	0	0	0	17.00
18.00	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0	18.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	513,776	0	149,914	18,241	132,690	30.00
31.00	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	327,016	0	119,127	43,213	81,239	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	732,528	0	96,540	14,185	51,451	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	507,912	0	35,720	798	33,849	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
61.00	PBP CLINICAL LAB. SERVICE-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	6,477	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	67,733	0	38,643	8,295	10,155	66.00
67.00	OCCUPATIONAL THERAPY	8,220	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	913	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	10,856	0	4,545	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	127,763	0	0	0	0	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	36,160	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
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	EMERGENCY	764,913	0	96,425	18,398	94,779	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	FAMILY PRACTICE	0	0	0	0	0	93.00
SPECIAL PURPOSE COST CENTERS							
115.00	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00	HOSPICE	0	0	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	4,205,096	0	796,823	147,470	441,059	118.00
NONREIMBURSABLE COST CENTERS							
190.00	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	1,085	0	8,268	0	0	190.00
191.00	RESEARCH	0	0	0	0	0	191.00
192.00	PHYSICIANS' PRIVATE OFFICES	2,371	0	18,065	0	0	192.00
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	OTHER NONREIMBURSABLE COST CENTERS	73,939	0	0	0	13,540	194.00
194.01	TOBACCO / CHILD GRANT	0	0	0	0	0	194.01
194.02	OUTPATIENT CLINICS	27,172	0	169,921	4,222	33,849	194.02
194.03	OTHER NONREIMBURSABLE COST CENTERS	77,032	0	0	0	0	194.03
194.04	SPN	41,718	0	317,801	0	216,637	194.04
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)	4,428,413	0	1,310,878	151,692	705,085	202.00

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COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151303

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

Worksheet B
Part I
Date/Time Prepared:
1/27/2012 9:36 am

Cost Center Description	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
	10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS						
1.00						1.00
2.00						2.00
4.00						4.00
5.00						5.00
6.00						6.00
7.00						7.00
8.00						8.00
9.00						9.00
10.00	82,615					10.00
11.00	0	281,117				11.00
12.00	0	0	0			12.00
13.00	0	7,350	0	477,335		13.00
14.00	0	7,559	0	0	191,953	14.00
15.00	0	8,035	0	0	48	15.00
16.00	0	15,615	0	0	26	16.00
17.00	0	0	0	0	0	17.00
18.00	0	0	0	0	0	18.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	82,615	73,910	0	238,669	18,055	30.00
31.00	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS						
50.00	0	32,954	0	57,609	20,803	50.00
51.00	0	0	0	0	0	51.00
52.00	0	0	0	0	0	52.00
53.00	0	0	0	0	0	53.00
54.00	0	54,530	0	61,724	12,441	54.00
55.00	0	0	0	0	0	55.00
56.00	0	0	0	0	0	56.00
57.00	0	0	0	0	0	57.00
58.00	0	0	0	0	0	58.00
59.00	0	0	0	0	0	59.00
60.00	0	4,218	0	49,379	0	60.00
60.01	0	0	0	0	0	60.01
61.00	0	0	0	0	0	61.00
62.00	0	0	0	0	0	62.00
63.00	0	0	0	0	0	63.00
64.00	0	0	0	0	0	64.00
65.00	0	0	0	0	1,906	65.00
66.00	0	0	0	0	1,776	66.00
67.00	0	0	0	0	0	67.00
68.00	0	0	0	0	0	68.00
69.00	0	0	0	0	0	69.00
70.00	0	0	0	0	0	70.00
71.00	0	0	0	0	104,957	71.00
72.00	0	0	0	0	2,380	72.00
73.00	0	0	0	0	0	73.00
74.00	0	0	0	0	0	74.00
75.00	0	0	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS						
88.00	0	0	0	0	0	88.00
91.00	0	60,924	0	69,954	29,281	91.00
92.00	0	0	0	0	0	92.00
93.00	0	0	0	0	0	93.00
SPECIAL PURPOSE COST CENTERS						
115.00	0	0	0	0	0	115.00
116.00	0	0	0	0	0	116.00
118.00	82,615	265,095	0	477,335	191,673	118.00
NONREIMBURSABLE COST CENTERS						
190.00	0	0	0	0	0	190.00
191.00	0	0	0	0	0	191.00
192.00	0	0	0	0	0	192.00
193.00	0	0	0	0	0	193.00
194.00	0	14,692	0	0	141	194.00
194.01	0	0	0	0	0	194.01
194.02	0	1,330	0	0	139	194.02
194.03	0	0	0	0	0	194.03
194.04	0	0	0	0	0	194.04
200.00	0	0	0	0	0	200.00
201.00	0	0	0	0	0	201.00
202.00	82,615	281,117	0	477,335	191,953	202.00

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COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151303

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

Worksheet B
Part I
Date/Time Prepared:
1/27/2012 9:36 am

Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE (SPECIFY)	Subtotal	
	15.00	16.00	17.00	18.00	24.00	
GENERAL SERVICE COST CENTERS						
1.00 CAP REL COSTS-BLDG & FIXT						1.00
2.00 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 EMPLOYEE BENEFITS						4.00
5.00 ADMINISTRATIVE & GENERAL						5.00
6.00 MAINTENANCE & REPAIRS						6.00
7.00 OPERATION OF PLANT						7.00
8.00 LAUNDRY & LINEN SERVICE						8.00
9.00 HOUSEKEEPING						9.00
10.00 DIETARY						10.00
11.00 CAFETERIA						11.00
12.00 MAINTENANCE OF PERSONNEL						12.00
13.00 NURSING ADMINISTRATION						13.00
14.00 CENTRAL SERVICES & SUPPLY						14.00
15.00 PHARMACY	862,585					15.00
16.00 MEDICAL RECORDS & LIBRARY	0	515,588				16.00
17.00 SOCIAL SERVICE	0	0	0			17.00
18.00 OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0		18.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	0	20,117	0	0	2,695,855	30.00
31.00 INTENSIVE CARE UNIT	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	68,867	0	0	1,672,389	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	159,416	0	0	3,247,147	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	104,570	0	0	2,167,788	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
61.00 PBP CLINICAL LAB. SERVICE-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	2,895	0	0	29,530	65.00
66.00 PHYSICAL THERAPY	0	14,864	0	0	332,344	66.00
67.00 OCCUPATIONAL THERAPY	0	1,428	0	0	32,814	67.00
68.00 SPEECH PATHOLOGY	0	125	0	0	3,611	68.00
69.00 ELECTROCARDIOLOGY	0	4,247	0	0	50,242	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	15,015	0	0	607,782	71.00
72.00 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	2,631	0	0	143,073	72.00
73.00 DRUGS CHARGED TO PATIENTS	862,585	27,507	0	0	890,092	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
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00 EMERGENCY	0	93,906	0	0	3,384,184	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00 FAMILY PRACTICE	0	0	0	0	0	93.00
SPECIAL PURPOSE COST CENTERS						
115.00 AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00 HOSPICE	0	0	0	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	862,585	515,588	0	0	15,256,851	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	12,411	190.00
191.00 RESEARCH	0	0	0	0	0	191.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	27,119	192.00
193.00 NONPAID WORKERS	0	0	0	0	0	193.00
194.00 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	310,678	194.00
194.01 TOBACCO / CHILD GRANT	0	0	0	0	0	194.01
194.02 OUTPATIENT CLINICS	0	0	0	0	313,206	194.02
194.03 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	294,116	194.03
194.04 SPN	0	0	0	0	693,720	194.04
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)	862,585	515,588	0	0	16,908,101	202.00

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Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	25.00	26.00	
GENERAL SERVICE COST CENTERS			
1.00	CAP REL COSTS-BLDG & FIXT		1.00
2.00	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	EMPLOYEE BENEFITS		4.00
5.00	ADMINISTRATIVE & GENERAL		5.00
6.00	MAINTENANCE & REPAIRS		6.00
7.00	OPERATION OF PLANT		7.00
8.00	LAUNDRY & LINEN SERVICE		8.00
9.00	HOUSEKEEPING		9.00
10.00	DIETARY		10.00
11.00	CAFETERIA		11.00
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
18.00	OTHER GENERAL SERVICE (SPECIFY)		18.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	0	2,695,855
31.00	INTENSIVE CARE UNIT	0	0
ANCILLARY SERVICE COST CENTERS			
50.00	OPERATING ROOM	0	1,672,389
51.00	RECOVERY ROOM	0	0
52.00	DELIVERY ROOM & LABOR ROOM	0	0
53.00	ANESTHESIOLOGY	0	0
54.00	RADIOLOGY - DIAGNOSTIC	0	3,247,147
55.00	RADIOLOGY - THERAPEUTIC	0	0
56.00	RADIOISOTOPE	0	0
57.00	CT SCAN	0	0
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0
59.00	CARDIAC CATHETERIZATION	0	0
60.00	LABORATORY	0	2,167,788
60.01	BLOOD LABORATORY	0	0
61.00	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0
63.00	BLOOD STORING, PROCESSING, & TRANS.	0	0
64.00	INTRAVENOUS THERAPY	0	0
65.00	RESPIRATORY THERAPY	0	29,530
66.00	PHYSICAL THERAPY	0	332,344
67.00	OCCUPATIONAL THERAPY	0	32,814
68.00	SPEECH PATHOLOGY	0	3,611
69.00	ELECTROCARDIOLOGY	0	50,242
70.00	ELECTROENCEPHALOGRAPHY	0	0
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	607,782
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	143,073
73.00	DRUGS CHARGED TO PATIENTS	0	890,092
74.00	RENAL DIALYSIS	0	0
75.00	ASC (NON-DISTINCT PART)	0	0
OUTPATIENT SERVICE COST CENTERS			
88.00	RURAL HEALTH CLINIC	0	0
91.00	EMERGENCY	0	3,384,184
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0
93.00	FAMILY PRACTICE	0	0
SPECIAL PURPOSE COST CENTERS			
115.00	AMBULATORY SURGICAL CENTER (D.P.)	0	0
116.00	HOSPICE	0	0
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	15,256,851
NONREIMBURSABLE COST CENTERS			
190.00	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	12,411
191.00	RESEARCH	0	0
192.00	PHYSICIANS' PRIVATE OFFICES	0	27,119
193.00	NONPAID WORKERS	0	0
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	310,678
194.01	TOBACCO / CHILD GRANT	0	0
194.02	OUTPATIENT CLINICS	0	313,206
194.03	OTHER NONREIMBURSABLE COST CENTERS	0	294,116
194.04	SPN	0	693,720
200.00	Cross Foot Adjustments	0	0
201.00	Negative Cost Centers	0	0
202.00	TOTAL (sum lines 118-201)	0	16,908,101

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ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151303

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

Worksheet B
Part II
Date/Time Prepared:
1/27/2012 9:36 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	
		BLDG & FIXT	MBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	EMPLOYEE BENEFITS	3,414	0	0	3,414	3,414 4.00
5.00	ADMINISTRATIVE & GENERAL	6,673	52,222	0	58,895	1,004 5.00
6.00	MAINTENANCE & REPAIRS	0	0	0	0	0 6.00
7.00	OPERATION OF PLANT	13,777	53,962	0	67,739	81 7.00
8.00	LAUNDRY & LINEN SERVICE	0	642	0	642	0 8.00
9.00	HOUSEKEEPING	1,856	12,132	0	13,988	130 9.00
10.00	DIETARY	1,135	5,982	0	7,117	19 10.00
11.00	CAFETERIA	0	12,327	0	12,327	49 11.00
12.00	MAINTENANCE OF PERSONNEL	0	0	0	0	0 12.00
13.00	NURSING ADMINISTRATION	0	1,402	0	1,402	123 13.00
14.00	CENTRAL SERVICES & SUPPLY	160	9,834	0	9,994	39 14.00
15.00	PHARMACY	1,774	5,534	0	7,308	93 15.00
16.00	MEDICAL RECORDS & LIBRARY	0	46,815	0	46,815	86 16.00
17.00	SOCIAL SERVICE	0	0	0	0	0 17.00
18.00	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0 18.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	17,709	55,458	0	73,167	519 30.00
31.00	INTENSIVE CARE UNIT	0	0	0	0	0 31.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	47,182	44,069	0	91,251	230 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	51,544	35,713	0	87,257	436 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	9,112	13,214	0	22,326	7 60.00
60.01	BLOOD LABORATORY	0	0	0	0	0 60.01
61.00	PBP CLINICAL LAB. SERVICE-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	1,751	14,295	0	16,046	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	1,681	0	1,681	11 69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0 70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0 71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
74.00	RENAL DIALYSIS	0	0	0	0	0 74.00
75.00	ASC (NON-DISTINCT PART)	0	0	0	0	0 75.00
OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	0	0	0 88.00
91.00	EMERGENCY	6,888	35,671	0	42,559	508 91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0 92.00
93.00	FAMILY PRACTICE	0	0	0	0	0 93.00
SPECIAL PURPOSE COST CENTERS						
115.00	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0 115.00
116.00	HOSPICE	0	0	0	0	0 116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	162,975	400,953	0	563,928	3,335 118.00
NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	3,058	0	3,058	0 190.00
191.00	RESEARCH	0	0	0	0	0 191.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	6,683	0	6,683	0 192.00
193.00	NONPAID WORKERS	0	0	0	0	0 193.00
194.00	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	74 194.00
194.01	TOBACCO / CHILD GRANT	0	0	0	0	0 194.01
194.02	OUTPATIENT CLINICS	106	62,859	0	62,965	5 194.02
194.03	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0 194.03
194.04	SPN	0	117,564	0	117,564	0 194.04
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	0 201.00

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ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151303

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

Worksheet B
Part II
Date/Time Prepared:
1/27/2012 9:36 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	2A	4.00	
202.00 TOTAL (sum lines 118-201)	163,081	591,117	0	754,198	3,414	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151303

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

Worksheet B
Part II
Date/Time Prepared:
1/27/2012 9:36 am

Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
	5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS						
1.00 CAP REL COSTS-BLDG & FIXT						1.00
2.00 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 EMPLOYEE BENEFITS						4.00
5.00 ADMINISTRATIVE & GENERAL	59,899					5.00
6.00 MAINTENANCE & REPAIRS	0	0				6.00
7.00 OPERATION OF PLANT	4,644	0	72,464			7.00
8.00 LAUNDRY & LINEN SERVICE	531	0	96	1,269		8.00
9.00 HOUSEKEEPING	2,240	0	1,813	336	18,507	9.00
10.00 DIETARY	120	0	894	35	746	10.00
11.00 CAFETERIA	878	0	1,842	0	0	11.00
12.00 MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00 NURSING ADMINISTRATION	1,652	0	210	0	0	13.00
14.00 CENTRAL SERVICES & SUPPLY	559	0	1,470	0	0	14.00
15.00 PHARMACY	2,956	0	827	0	133	15.00
16.00 MEDICAL RECORDS & LIBRARY	1,311	0	6,996	0	89	16.00
17.00 SOCIAL SERVICE	0	0	0	0	0	17.00
18.00 OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0	18.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	6,950	0	8,287	153	3,483	30.00
31.00 INTENSIVE CARE UNIT	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	4,423	0	6,585	361	2,132	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	9,909	0	5,337	119	1,350	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	6,870	0	1,975	7	888	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
61.00 PBP CLINICAL LAB. SERVICE-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	88	0	0	0	0	65.00
66.00 PHYSICAL THERAPY	916	0	2,136	69	267	66.00
67.00 OCCUPATIONAL THERAPY	111	0	0	0	0	67.00
68.00 SPEECH PATHOLOGY	12	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	147	0	251	0	0	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	1,728	0	0	0	0	71.00
72.00 IMPLANTABLE DEVICES CHARGED TO PATIENTS	489	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
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00 EMERGENCY	10,344	0	5,330	154	2,488	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00 FAMILY PRACTICE	0	0	0	0	0	93.00
SPECIAL PURPOSE COST CENTERS						
115.00 AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00 HOSPICE	0	0	0	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	56,878	0	44,049	1,234	11,576	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	15	0	457	0	0	190.00
191.00 RESEARCH	0	0	0	0	0	191.00
192.00 PHYSICIANS' PRIVATE OFFICES	32	0	999	0	0	192.00
193.00 NONPAID WORKERS	0	0	0	0	0	193.00
194.00 OTHER NONREIMBURSABLE COST CENTERS	1,000	0	0	0	355	194.00
194.01 TOBACCO / CHILD GRANT	0	0	0	0	0	194.01
194.02 OUTPATIENT CLINICS	368	0	9,393	35	888	194.02
194.03 OTHER NONREIMBURSABLE COST CENTERS	1,042	0	0	0	0	194.03
194.04 SPN	564	0	17,566	0	5,688	194.04
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)	59,899	0	72,464	1,269	18,507	202.00

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ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151303

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

Worksheet B Part II Date/Time Prepared: 1/27/2012 9:36 am

Cost Center Description	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
	10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS						
1.00 CAP REL COSTS-BLDG & FIXT						1.00
2.00 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 EMPLOYEE BENEFITS						4.00
5.00 ADMINISTRATIVE & GENERAL						5.00
6.00 MAINTENANCE & REPAIRS						6.00
7.00 OPERATION OF PLANT						7.00
8.00 LAUNDRY & LINEN SERVICE						8.00
9.00 HOUSEKEEPING						9.00
10.00 DIETARY	8,931					10.00
11.00 CAFETERIA	0	15,096				11.00
12.00 MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00 NURSING ADMINISTRATION	0	395	0	3,782		13.00
14.00 CENTRAL SERVICES & SUPPLY	0	406	0	0	12,468	14.00
15.00 PHARMACY	0	432	0	0	3	15.00
16.00 MEDICAL RECORDS & LIBRARY	0	839	0	0	2	16.00
17.00 SOCIAL SERVICE	0	0	0	0	0	17.00
18.00 OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0	18.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	8,931	3,967	0	1,892	1,173	30.00
31.00 INTENSIVE CARE UNIT	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	1,770	0	456	1,351	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	2,928	0	489	808	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	227	0	391	0	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
61.00 PBP CLINICAL LAB. SERVICE-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	124	65.00
66.00 PHYSICAL THERAPY	0	0	0	0	115	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	6,817	71.00
72.00 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	155	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
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00 EMERGENCY	0	3,272	0	554	1,902	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00 FAMILY PRACTICE	0	0	0	0	0	93.00
SPECIAL PURPOSE COST CENTERS						
115.00 AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00 HOSPICE	0	0	0	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	8,931	14,236	0	3,782	12,450	118.00
NONREIMBURSABLE COST CENTERS						
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 COST CENTERS	0	789	0	0	9	194.00
194.01 TOBACCO / CHILD GRANT	0	0	0	0	0	194.01
194.02 OUTPATIENT CLINICS	0	71	0	0	9	194.02
194.03 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.03
194.04 SPN	0	0	0	0	0	194.04
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)	8,931	15,096	0	3,782	12,468	202.00

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ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151303

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

Worksheet B
Part II
Date/Time Prepared:
1/27/2012 9:36 am

Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE (SPECIFY)	Subtotal	
	15.00	16.00	17.00	18.00	24.00	
GENERAL SERVICE COST CENTERS						
1.00 CAP REL COSTS-BLDG & FIXT						1.00
2.00 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 EMPLOYEE BENEFITS						4.00
5.00 ADMINISTRATIVE & GENERAL						5.00
6.00 MAINTENANCE & REPAIRS						6.00
7.00 OPERATION OF PLANT						7.00
8.00 LAUNDRY & LINEN SERVICE						8.00
9.00 HOUSEKEEPING						9.00
10.00 DIETARY						10.00
11.00 CAFETERIA						11.00
12.00 MAINTENANCE OF PERSONNEL						12.00
13.00 NURSING ADMINISTRATION						13.00
14.00 CENTRAL SERVICES & SUPPLY						14.00
15.00 PHARMACY	11,752					15.00
16.00 MEDICAL RECORDS & LIBRARY	0	56,138				16.00
17.00 SOCIAL SERVICE	0	0	0			17.00
18.00 OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0		18.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	0	2,190	0	0	110,712	30.00
31.00 INTENSIVE CARE UNIT	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	7,498	0	0	116,057	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	17,361	0	0	125,994	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	11,385	0	0	44,076	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
61.00 PBP CLINICAL LAB. SERVICE-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	315	0	0	527	65.00
66.00 PHYSICAL THERAPY	0	1,618	0	0	21,167	66.00
67.00 OCCUPATIONAL THERAPY	0	155	0	0	266	67.00
68.00 SPEECH PATHOLOGY	0	14	0	0	26	68.00
69.00 ELECTROCARDIOLOGY	0	462	0	0	2,552	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,635	0	0	10,180	71.00
72.00 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	286	0	0	930	72.00
73.00 DRUGS CHARGED TO PATIENTS	11,752	2,995	0	0	14,747	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
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00 EMERGENCY	0	10,224	0	0	77,335	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00 FAMILY PRACTICE	0	0	0	0	0	93.00
SPECIAL PURPOSE COST CENTERS						
115.00 AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00 HOSPICE	0	0	0	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	11,752	56,138	0	0	524,569	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	3,530	190.00
191.00 RESEARCH	0	0	0	0	0	191.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	7,714	192.00
193.00 NONPAID WORKERS	0	0	0	0	0	193.00
194.00 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	2,227	194.00
194.01 TOBACCO / CHILD GRANT	0	0	0	0	0	194.01
194.02 OUTPATIENT CLINICS	0	0	0	0	73,734	194.02
194.03 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	1,042	194.03
194.04 SPN	0	0	0	0	141,382	194.04
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)	11,752	56,138	0	0	754,198	202.00

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ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151303

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

Worksheet B
Part II
Date/Time Prepared:
1/27/2012 9:36 am

Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	25.00	26.00	
GENERAL SERVICE COST CENTERS			
1.00 CAP REL COSTS-BLDG & FIXT			1.00
2.00 CAP REL COSTS-MVBLE EQUIP			2.00
4.00 EMPLOYEE BENEFITS			4.00
5.00 ADMINISTRATIVE & GENERAL			5.00
6.00 MAINTENANCE & REPAIRS			6.00
7.00 OPERATION OF PLANT			7.00
8.00 LAUNDRY & LINEN SERVICE			8.00
9.00 HOUSEKEEPING			9.00
10.00 DIETARY			10.00
11.00 CAFETERIA			11.00
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
18.00 OTHER GENERAL SERVICE (SPECIFY)			18.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00 ADULTS & PEDIATRICS	0	110,712	30.00
31.00 INTENSIVE CARE UNIT	0	0	31.00
ANCILLARY SERVICE COST CENTERS			
50.00 OPERATING ROOM	0	116,057	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	125,994	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	44,076	60.00
60.01 BLOOD LABORATORY	0	0	60.01
61.00 PBP CLINICAL LAB. SERVICE-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	527	65.00
66.00 PHYSICAL THERAPY	0	21,167	66.00
67.00 OCCUPATIONAL THERAPY	0	266	67.00
68.00 SPEECH PATHOLOGY	0	26	68.00
69.00 ELECTROCARDIOLOGY	0	2,552	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	10,180	71.00
72.00 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	930	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	14,747	73.00
74.00 RENAL DIALYSIS	0	0	74.00
75.00 ASC (NON-DISTINCT PART)	0	0	75.00
OUTPATIENT SERVICE COST CENTERS			
88.00 RURAL HEALTH CLINIC	0	0	88.00
91.00 EMERGENCY	0	77,335	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
93.00 FAMILY PRACTICE	0	0	93.00
SPECIAL PURPOSE COST CENTERS			
115.00 AMBULATORY SURGICAL CENTER (D.P.)	0	0	115.00
116.00 HOSPICE	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	524,569	118.00
NONREIMBURSABLE COST CENTERS			
190.00 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	3,530	190.00
191.00 RESEARCH	0	0	191.00
192.00 PHYSICIANS' PRIVATE OFFICES	0	7,714	192.00
193.00 NONPAID WORKERS	0	0	193.00
194.00 OTHER NONREIMBURSABLE COST CENTERS	0	2,227	194.00
194.01 TOBACCO / CHILD GRANT	0	0	194.01
194.02 OUTPATIENT CLINICS	0	73,734	194.02
194.03 OTHER NONREIMBURSABLE COST CENTERS	0	1,042	194.03
194.04 SPN	0	141,382	194.04
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	754,198	202.00

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Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQURE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 CAP REL COSTS-BLDG & FIXT	69,965					1.00
2.00 CAP REL COSTS-MVBLE EQUIP		0				2.00
4.00 EMPLOYEE BENEFITS	0	0	6,107,454			4.00
5.00 ADMINISTRATIVE & GENERAL	6,181	0	1,790,274	-4,428,413	12,479,688	5.00
6.00 MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00 OPERATION OF PLANT	6,387	0	145,110	0	967,545	7.00
8.00 LAUNDRY & LINEN SERVICE	76	0	0	0	110,681	8.00
9.00 HOUSEKEEPING	1,436	0	233,115	0	466,595	9.00
10.00 DIETARY	708	0	34,008	0	24,942	10.00
11.00 CAFETERIA	1,459	0	87,624	0	182,895	11.00
12.00 MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00 NURSING ADMINISTRATION	166	0	220,544	0	344,093	13.00
14.00 CENTRAL SERVICES & SUPPLY	1,164	0	69,509	0	116,478	14.00
15.00 PHARMACY	655	0	166,352	0	615,910	15.00
16.00 MEDICAL RECORDS & LIBRARY	5,541	0	154,693	0	273,102	16.00
17.00 SOCIAL SERVICE	0	0	0	0	0	17.00
18.00 OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0	18.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	6,564	0	929,141	0	1,447,868	30.00
31.00 INTENSIVE CARE UNIT	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	5,216	0	412,299	0	921,561	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	4,227	0	780,663	0	2,064,332	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	1,564	0	12,442	0	1,431,342	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
61.00 PBP CLINICAL LAB. SERVICE-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	18,252	65.00
66.00 PHYSICAL THERAPY	1,692	0	0	0	190,878	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0	23,166	67.00
68.00 SPEECH PATHOLOGY	0	0	0	0	2,573	68.00
69.00 ELECTROCARDIOLOGY	199	0	19,991	0	30,594	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	360,047	71.00
72.00 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	101,902	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
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00 EMERGENCY	4,222	0	909,641	0	2,155,604	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00 FAMILY PRACTICE	0	0	0	0	0	93.00
SPECIAL PURPOSE COST CENTERS						
115.00 AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00 HOSPICE	0	0	0	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	47,457	0	5,965,406	-4,428,413	11,850,360	118.00
NONREIMBURSABLE COST CENTERS						
190.00 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	362	0	0	0	3,058	190.00
191.00 RESEARCH	0	0	0	0	0	191.00
192.00 PHYSICIANS' PRIVATE OFFICES	791	0	0	0	6,683	192.00
193.00 NONPAID WORKERS	0	0	0	0	0	193.00
194.00 OTHER NONREIMBURSABLE COST CENTERS	0	0	132,625	0	208,366	194.00
194.01 TOBACCO / CHILD GRANT	0	0	0	0	0	194.01
194.02 OUTPATIENT CLINICS	7,440	0	9,423	0	76,573	194.02
194.03 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	217,084	194.03
194.04 SPN	13,915	0	0	0	117,564	194.04
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00

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COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151303

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

Worksheet B-1

Date/Time Prepared:
1/27/2012 9:36 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
	1.00	2.00				
202.00 Cost to be allocated (per Wkst. B, Part I)	591,117	0	2,233,979		4,428,413	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	8.448753	0.000000	0.365779		0.354850	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)			3,414		59,899	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)			0.000559		0.004800	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151303

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

Worksheet B-1

Date/Time Prepared:
1/27/2012 9:36 am

Cost Center Description	MAINTENANCE & REPAIRS (SQ. FEET)	OPERATION OF PLANT (SQ. FEET)	LAUNDRY & LINEN SERVICE (ITEMIZED BILLS)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
	6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS						
1.00						1.00
2.00						2.00
4.00						4.00
5.00						5.00
6.00	0					6.00
7.00	0	57,397				7.00
8.00	0	76	110,039			8.00
9.00	0	1,436	29,105	4,166		9.00
10.00	0	708	3,060	168	100	10.00
11.00	0	1,459	0	0	0	11.00
12.00	0	0	0	0	0	12.00
13.00	0	166	0	0	0	13.00
14.00	0	1,164	0	0	0	14.00
15.00	0	655	0	30	0	15.00
16.00	0	5,541	0	20	0	16.00
17.00	0	0	0	0	0	17.00
18.00	0	0	0	0	0	18.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	0	6,564	13,232	784	100	30.00
31.00	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS						
50.00	0	5,216	31,347	480	0	50.00
51.00	0	0	0	0	0	51.00
52.00	0	0	0	0	0	52.00
53.00	0	0	0	0	0	53.00
54.00	0	4,227	10,290	304	0	54.00
55.00	0	0	0	0	0	55.00
56.00	0	0	0	0	0	56.00
57.00	0	0	0	0	0	57.00
58.00	0	0	0	0	0	58.00
59.00	0	0	0	0	0	59.00
60.00	0	1,564	579	200	0	60.00
60.01	0	0	0	0	0	60.01
61.00	0	0	0	0	0	61.00
62.00	0	0	0	0	0	62.00
63.00	0	0	0	0	0	63.00
64.00	0	0	0	0	0	64.00
65.00	0	0	0	0	0	65.00
66.00	0	1,692	6,017	60	0	66.00
67.00	0	0	0	0	0	67.00
68.00	0	0	0	0	0	68.00
69.00	0	199	0	0	0	69.00
70.00	0	0	0	0	0	70.00
71.00	0	0	0	0	0	71.00
72.00	0	0	0	0	0	72.00
73.00	0	0	0	0	0	73.00
74.00	0	0	0	0	0	74.00
75.00	0	0	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS						
88.00	0	0	0	0	0	88.00
91.00	0	4,222	13,346	560	0	91.00
92.00	0	0	0	0	0	92.00
93.00	0	0	0	0	0	93.00
SPECIAL PURPOSE COST CENTERS						
115.00	0	0	0	0	0	115.00
116.00	0	0	0	0	0	116.00
118.00	0	34,889	106,976	2,606	100	118.00
NONREIMBURSABLE COST CENTERS						
190.00	0	362	0	0	0	190.00
191.00	0	0	0	0	0	191.00
192.00	0	791	0	0	0	192.00
193.00	0	0	0	0	0	193.00
194.00	0	0	0	80	0	194.00
194.01	0	0	0	0	0	194.01
194.02	0	7,440	3,063	200	0	194.02
194.03	0	0	0	0	0	194.03
194.04	0	13,915	0	1,280	0	194.04
200.00						200.00
201.00						201.00
202.00	0	1,310,878	151,692	705,085	82,615	202.00
203.00	0.000000	22,838789	1,378529	169,247480	826,150000	203.00

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COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151303

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

Worksheet B-1

Date/Time Prepared:
1/27/2012 9:36 am

Cost Center Description	MAINTENANCE & REPAIRS (SQ. FEET)	OPERATION OF PLANT (SQ. FEET)	LAUNDRY & LINEN SERVICE (ITEMIZED BILLS)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
	6:00	7:00	8:00	9:00	10:00	
204.00 Cost to be allocated (per Wkst. B, Part II)	0	72,464	1,269	18,507	8,931	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)	0.000000	1.262505	0.011532	4.442391	89.310000	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151303

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

Worksheet B-1

Date/Time Prepared:
1/27/2012 9:36 am

Cost Center Description	CAFETERIA (HOURS)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
	11.00	12.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS						
1.00 CAP REL COSTS-BLDG & FIXT						1.00
2.00 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 EMPLOYEE BENEFITS						4.00
5.00 ADMINISTRATIVE & GENERAL						5.00
6.00 MAINTENANCE & REPAIRS						6.00
7.00 OPERATION OF PLANT						7.00
8.00 LAUNDRY & LINEN SERVICE						8.00
9.00 HOUSEKEEPING						9.00
10.00 DIETARY						10.00
11.00 CAFETERIA	159,214					11.00
12.00 MAINTENANCE OF PERSONNEL	0	0				12.00
13.00 NURSING ADMINISTRATION	4,163	0	116			13.00
14.00 CENTRAL SERVICES & SUPPLY	4,281	0	0	361,111		14.00
15.00 PHARMACY	4,551	0	0	91	100	15.00
16.00 MEDICAL RECORDS & LIBRARY	8,844	0	0	48	0	16.00
17.00 SOCIAL SERVICE	0	0	0	0	0	17.00
18.00 OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0	18.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	41,859	0	58	33,966	0	30.00
31.00 INTENSIVE CARE UNIT	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	18,664	0	14	39,136	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	30,884	0	15	23,404	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	2,389	0	12	0	0	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
61.00 PBP CLINICAL LAB. SERVICE-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	3,585	0	65.00
66.00 PHYSICAL THERAPY	0	0	0	3,341	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	197,450	0	71.00
72.00 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	4,478	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	100	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
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00 EMERGENCY	34,505	0	17	55,085	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00 FAMILY PRACTICE	0	0	0	0	0	93.00
SPECIAL PURPOSE COST CENTERS						
115.00 AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00 HOSPICE	0	0	0	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	150,140	0	116	360,584	100	118.00
NONREIMBURSABLE COST CENTERS						
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 COST CENTERS	8,321	0	0	265	0	194.00
194.01 TOBACCO / CHILD GRANT	0	0	0	0	0	194.01
194.02 OUTPATIENT CLINICS	753	0	0	262	0	194.02
194.03 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.03
194.04 SPN	0	0	0	0	0	194.04
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)	281,117	0	477,335	191,953	862,585	202.00

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COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151303

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

Worksheet B-1

Date/Time Prepared:
1/27/2012 9:36 am

Cost Center Description	CAFETERIA (HOURS)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
	11.00	12.00	13.00	14.00	15.00	
203.00 Unit cost multiplier (wkst. B, Part I)	1.765655	0.000000	4,114.956897	0.531562	8,625.850000	203.00
204.00 Cost to be allocated (per wkst. B, Part II)	15,096	0	3,782	12,468	11,752	204.00
205.00 Unit cost multiplier (wkst. B, Part II)	0.094816	0.000000	32.603448	0.034527	117.520000	205.00

Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	OTHER GENERAL SERVICE (SPECIFY)		
GENERAL SERVICE COST CENTERS					
1.00 CAP REL COSTS-BLDG & FIXT					1.00
2.00 CAP REL COSTS-MVBLE EQUIP					2.00
4.00 EMPLOYEE BENEFITS					4.00
5.00 ADMINISTRATIVE & GENERAL					5.00
6.00 MAINTENANCE & REPAIRS					6.00
7.00 OPERATION OF PLANT					7.00
8.00 LAUNDRY & LINEN SERVICE					8.00
9.00 HOUSEKEEPING					9.00
10.00 DIETARY					10.00
11.00 CAFETERIA					11.00
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	44,341,111				16.00
17.00 SOCIAL SERVICE	0	0			17.00
18.00 OTHER GENERAL SERVICE (SPECIFY)	0	0	0		18.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 ADULTS & PEDIATRICS	1,730,041	0	0		30.00
31.00 INTENSIVE CARE UNIT	0	0	0		31.00
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	5,922,490	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	13,710,693	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	8,992,940	0	0		60.00
60.01 BLOOD LABORATORY	0	0	0		60.01
61.00 PBP CLINICAL LAB. SERVICE-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	248,977	0	0		65.00
66.00 PHYSICAL THERAPY	1,278,329	0	0		66.00
67.00 OCCUPATIONAL THERAPY	122,802	0	0		67.00
68.00 SPEECH PATHOLOGY	10,727	0	0		68.00
69.00 ELECTROCARDIOLOGY	365,237	0	0		69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	1,291,261	0	0		71.00
72.00 IMPLANTABLE DEVICES CHARGED TO PATIENTS	226,227	0	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	2,365,568	0	0		73.00
74.00 RENAL DIALYSIS	0	0	0		74.00
75.00 ASC (NON-DISTINCT PART)	0	0	0		75.00
OUTPATIENT SERVICE COST CENTERS					
88.00 RURAL HEALTH CLINIC	0	0	0		88.00
91.00 EMERGENCY	8,075,819	0	0		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
93.00 FAMILY PRACTICE	0	0	0		93.00
SPECIAL PURPOSE COST CENTERS					
115.00 AMBULATORY SURGICAL CENTER (D.P.)	0	0	0		115.00
116.00 HOSPICE	0	0	0		116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	44,341,111	0	0		118.00
NONREIMBURSABLE COST CENTERS					
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 COST CENTERS	0	0	0		194.00
194.01 TOBACCO / CHILD GRANT	0	0	0		194.01
194.02 OUTPATIENT CLINICS	0	0	0		194.02
194.03 OTHER NONREIMBURSABLE COST CENTERS	0	0	0		194.03
194.04 SPN	0	0	0		194.04
200.00 Cross Foot Adjustments					200.00

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COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151303

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

Worksheet B-1

Date/Time Prepared:
1/27/2012 9:36 am

Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	OTHER GENERAL SERVICE (SPECIFY)		
201.00 Negative Cost Centers	16.00	17.00	18.00		201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	515,588	0	0		202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	0.011628	0.000000	0.000000		203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	56,138	0	0		204.00
205.00 Unit cost multiplier (Wkst. B, Part II)	0.001266	0.000000	0.000000		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151303

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

worksheet C
Part I
Date/Time Prepared:
1/27/2012 9:36 am

Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Title XVIII Hospital Cost		
			Total Costs	Costs	
				RCE Disallowance	Total Costs
1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 ADULTS & PEDIATRICS	2,695,855		2,695,855	0	30.00
31.00 INTENSIVE CARE UNIT	0		0	0	31.00
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	1,672,389		1,672,389	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	3,247,147		3,247,147	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	2,167,788		2,167,788	0	60.00
60.01 BLOOD LABORATORY	0		0	0	60.01
61.00 PBP CLINICAL LAB. SERVICE-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	29,530	0	29,530	0	65.00
66.00 PHYSICAL THERAPY	332,344	0	332,344	0	66.00
67.00 OCCUPATIONAL THERAPY	32,814	0	32,814	0	67.00
68.00 SPEECH PATHOLOGY	3,611	0	3,611	0	68.00
69.00 ELECTROCARDIOLOGY	50,242		50,242	0	69.00
70.00 ELECTROENCEPHALOGRAPHY	0		0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	607,782		607,782	0	71.00
72.00 IMPLANTABLE DEVICES CHARGED TO PATIENTS	143,073		143,073	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	890,092		890,092	0	73.00
74.00 RENAL DIALYSIS	0		0	0	74.00
75.00 ASC (NON-DISTINCT PART)	0		0	0	75.00
OUTPATIENT SERVICE COST CENTERS					
88.00 RURAL HEALTH CLINIC	0		0	0	88.00
91.00 EMERGENCY	3,384,184		3,384,184	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	358,315		358,315	0	92.00
93.00 FAMILY PRACTICE	0		0	0	93.00
SPECIAL PURPOSE COST CENTERS					
115.00 AMBULATORY SURGICAL CENTER (D.P.)	0		0	0	115.00
116.00 HOSPICE	0		0	0	116.00
200.00 Subtotal (see instructions)	15,615,166	0	15,615,166	0	200.00
201.00 Less Observation Beds	358,315		358,315	0	201.00
202.00 Total (see instructions)	15,256,851	0	15,256,851	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151303

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

Worksheet C
Part I
Date/Time Prepared:
1/27/2012 9:36 am

Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	Cost
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	1,477,973		1,477,973			30.00
31.00 INTENSIVE CARE UNIT	0		0			31.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	65,589	5,856,900	5,922,489	0.282379	0.000000	50.00
51.00 RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00 ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00 RADIOLOGY - DIAGNOSTIC	443,275	13,267,418	13,710,693	0.236833	0.000000	54.00
55.00 RADIOLOGY - THERAPEUTIC	0	0	0	0.000000	0.000000	55.00
56.00 RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
57.00 CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00 LABORATORY	513,388	8,479,553	8,992,941	0.241054	0.000000	60.00
60.01 BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
61.00 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0	0	0.000000	0.000000	61.00
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0.000000	0.000000	62.00
63.00 BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0.000000	0.000000	63.00
64.00 INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
65.00 RESPIRATORY THERAPY	231,185	17,792	248,977	0.118605	0.000000	65.00
66.00 PHYSICAL THERAPY	215,261	1,063,068	1,278,329	0.259983	0.000000	66.00
67.00 OCCUPATIONAL THERAPY	67,002	55,800	122,802	0.267211	0.000000	67.00
68.00 SPEECH PATHOLOGY	5,666	5,061	10,727	0.336627	0.000000	68.00
69.00 ELECTROCARDIOLOGY	80,126	285,111	365,237	0.137560	0.000000	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	302,857	988,404	1,291,261	0.470689	0.000000	71.00
72.00 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	226,227	226,227	0.632431	0.000000	72.00
73.00 DRUGS CHARGED TO PATIENTS	942,162	1,423,406	2,365,568	0.376270	0.000000	73.00
74.00 RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
75.00 ASC (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	75.00
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0			88.00
91.00 EMERGENCY	504,693	7,571,126	8,075,819	0.419051	0.000000	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	252,068	252,068	1.421501	0.000000	92.00
93.00 FAMILY PRACTICE	0	0	0	0.000000	0.000000	93.00
SPECIAL PURPOSE COST CENTERS						
115.00 AMBULATORY SURGICAL CENTER (D.P.)	0	0	0			115.00
116.00 HOSPICE	0	0	0			116.00
200.00 Subtotal (see instructions)	4,849,177	39,491,934	44,341,111			200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	4,849,177	39,491,934	44,341,111			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151303

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

Worksheet C
Part I
Date/Time Prepared:
1/27/2012 9:36 am

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS				30.00
31.00	INTENSIVE CARE UNIT				31.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.000000			50.00
51.00	RECOVERY ROOM	0.000000			51.00
52.00	DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	ANESTHESIOLOGY	0.000000			53.00
54.00	RADIOLOGY - DIAGNOSTIC	0.000000			54.00
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. SERVICE-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
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000			72.00
73.00	DRUGS CHARGED TO PATIENTS	0.000000			73.00
74.00	RENAL DIALYSIS	0.000000			74.00
75.00	ASC (NON-DISTINCT PART)	0.000000			75.00
OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC				88.00
91.00	EMERGENCY	0.000000			91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
93.00	FAMILY PRACTICE	0.000000			93.00
SPECIAL PURPOSE COST CENTERS					
115.00	AMBULATORY SURGICAL CENTER (D.P.)				115.00
116.00	HOSPICE				116.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151303

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

Worksheet C
Part I
Date/Time Prepared:
1/27/2012 9:36 am

Cost Center Description	Total Cost (from wkst. B, Part I, col. 26)	Therapy Limit Adj.	Title XIX		Hospital		Cost
			Total Costs	RCE Disallowance	Total Costs		
							3.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 ADULTS & PEDIATRICS	2,695,855		2,695,855	0	0	0	30.00
31.00 INTENSIVE CARE UNIT	0		0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS							
50.00 OPERATING ROOM	1,672,389		1,672,389	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	3,247,147		3,247,147	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	2,167,788		2,167,788	0	0	0	60.00
60.01 BLOOD LABORATORY	0		0	0	0	0	60.01
61.00 PBP CLINICAL LAB. SERVICE-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	29,530	0	29,530	0	0	0	65.00
66.00 PHYSICAL THERAPY	332,344	0	332,344	0	0	0	66.00
67.00 OCCUPATIONAL THERAPY	32,814	0	32,814	0	0	0	67.00
68.00 SPEECH PATHOLOGY	3,611	0	3,611	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	50,242		50,242	0	0	0	69.00
70.00 ELECTROENCEPHALOGRAPHY	0		0	0	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	607,782		607,782	0	0	0	71.00
72.00 IMPLANTABLE DEVICES CHARGED TO PATIENTS	143,073		143,073	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	890,092		890,092	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
OUTPATIENT SERVICE COST CENTERS							
88.00 RURAL HEALTH CLINIC	0		0	0	0	0	88.00
91.00 EMERGENCY	3,384,184		3,384,184	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	359,352		359,352	0	0	0	92.00
93.00 FAMILY PRACTICE	0		0	0	0	0	93.00
SPECIAL PURPOSE COST CENTERS							
115.00 AMBULATORY SURGICAL CENTER (D.P.)	0		0	0	0	0	115.00
116.00 HOSPICE	0		0	0	0	0	116.00
200.00 Subtotal (see instructions)	15,616,203	0	15,616,203	0	0	0	200.00
201.00 Less observation Beds	359,352		359,352	0	0	0	201.00
202.00 Total (see instructions)	15,256,851	0	15,256,851	0	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151303

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

Worksheet C
Part I
Date/Time Prepared:
1/27/2012 9:36 am

Cost Center Description	Charges			Hospital Cost or Other Ratio	TEFRA Inpatient Ratio	Cost
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	1,477,973		1,477,973			30.00
31.00 INTENSIVE CARE UNIT	0		0			31.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	65,589	5,856,900	5,922,489	0.282379	0.000000	50.00
51.00 RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00 ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00 RADIOLOGY - DIAGNOSTIC	443,275	13,267,418	13,710,693	0.236833	0.000000	54.00
55.00 RADIOLOGY - THERAPEUTIC	0	0	0	0.000000	0.000000	55.00
56.00 RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
57.00 CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00 LABORATORY	513,388	8,479,553	8,992,941	0.241054	0.000000	60.00
60.01 BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
61.00 PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0	0	0.000000	0.000000	61.00
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0.000000	0.000000	62.00
63.00 BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0.000000	0.000000	63.00
64.00 INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
65.00 RESPIRATORY THERAPY	231,185	17,792	248,977	0.118605	0.000000	65.00
66.00 PHYSICAL THERAPY	215,261	1,063,068	1,278,329	0.259983	0.000000	66.00
67.00 OCCUPATIONAL THERAPY	67,002	55,800	122,802	0.267211	0.000000	67.00
68.00 SPEECH PATHOLOGY	5,666	5,061	10,727	0.336627	0.000000	68.00
69.00 ELECTROCARDIOLOGY	80,126	285,111	365,237	0.137560	0.000000	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	302,857	988,404	1,291,261	0.470689	0.000000	71.00
72.00 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	226,227	226,227	0.632431	0.000000	72.00
73.00 DRUGS CHARGED TO PATIENTS	942,162	1,423,406	2,365,568	0.376270	0.000000	73.00
74.00 RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
75.00 ASC (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	75.00
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0	0.000000	0.000000	88.00
91.00 EMERGENCY	504,693	7,571,126	8,075,819	0.419051	0.000000	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	252,068	252,068	1.425615	0.000000	92.00
93.00 FAMILY PRACTICE	0	0	0	0.000000	0.000000	93.00
SPECIAL PURPOSE COST CENTERS						
115.00 AMBULATORY SURGICAL CENTER (D.P.)	0	0	0			115.00
116.00 HOSPICE	0	0	0			116.00
200.00 Subtotal (see instructions)	4,849,177	39,491,934	44,341,111			200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	4,849,177	39,491,934	44,341,111			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151303

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

Worksheet C
Part I
Date/Time Prepared:
1/27/2012 9:36 am

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS				30.00
31.00	INTENSIVE CARE UNIT				31.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.000000			50.00
51.00	RECOVERY ROOM	0.000000			51.00
52.00	DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	ANESTHESIOLOGY	0.000000			53.00
54.00	RADIOLOGY - DIAGNOSTIC	0.000000			54.00
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. SERVICE-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
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000			72.00
73.00	DRUGS CHARGED TO PATIENTS	0.000000			73.00
74.00	RENAL DIALYSIS	0.000000			74.00
75.00	ASC (NON-DISTINCT PART)	0.000000			75.00
OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	0.000000			88.00
91.00	EMERGENCY	0.000000			91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
93.00	FAMILY PRACTICE	0.000000			93.00
SPECIAL PURPOSE COST CENTERS					
115.00	AMBULATORY SURGICAL CENTER (D.P.)				115.00
116.00	HOSPICE				116.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

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

Provider CCN: 151303

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

Worksheet C Part II Date/Time Prepared: 1/27/2012 9:36 am

Cost Center Description	Title XIX			Hospital		Cost
	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	1,672,389	116,057	1,556,332	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	3,247,147	125,994	3,121,153	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	2,167,788	44,076	2,123,712	0	0	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
61.00 PBP CLINICAL LAB. SERVICE-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	29,530	527	29,003	0	0	65.00
66.00 PHYSICAL THERAPY	332,344	21,167	311,177	0	0	66.00
67.00 OCCUPATIONAL THERAPY	32,814	266	32,548	0	0	67.00
68.00 SPEECH PATHOLOGY	3,611	26	3,585	0	0	68.00
69.00 ELECTROCARDIOLOGY	50,242	2,552	47,690	0	0	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	607,782	10,180	597,602	0	0	71.00
72.00 IMPLANTABLE DEVICES CHARGED TO PATIENTS	143,073	930	142,143	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	890,092	14,747	875,345	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
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00 EMERGENCY	3,384,184	77,335	3,306,849	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	359,352	0	359,352	0	0	92.00
93.00 FAMILY PRACTICE	0	0	0	0	0	93.00
SPECIAL PURPOSE COST CENTERS						
115.00 AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116.00 HOSPICE	0	0	0	0	0	116.00
200.00 Subtotal (sum of lines 50 thru 199)	12,920,348	413,857	12,506,491	0	0	200.00
201.00 Less Observation Beds	359,352	0	359,352	0	0	201.00
202.00 Total (line 200 minus line 201)	12,560,996	54,505	12,147,139	0	0	202.00

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

Provider CCN: 151303

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

Worksheet C Part II Date/Time Prepared: 1/27/2012 9:36 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		
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	1,672,389	5,922,489	0.282379		50.00
51.00	RECOVERY ROOM	0	0	0.000000		51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0.000000		52.00
53.00	ANESTHESIOLOGY	0	0	0.000000		53.00
54.00	RADIOLOGY - DIAGNOSTIC	3,247,147	13,710,693	0.236833		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	2,167,788	8,992,941	0.241054		60.00
60.01	BLOOD LABORATORY	0	0	0.000000		60.01
61.00	PBP CLINICAL LAB. SERVICE-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	29,530	248,977	0.118605		65.00
66.00	PHYSICAL THERAPY	332,344	1,278,329	0.259983		66.00
67.00	OCCUPATIONAL THERAPY	32,814	122,802	0.267211		67.00
68.00	SPEECH PATHOLOGY	3,611	10,727	0.336627		68.00
69.00	ELECTROCARDIOLOGY	50,242	365,237	0.137560		69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0.000000		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	607,782	1,291,261	0.470689		71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	143,073	226,227	0.632431		72.00
73.00	DRUGS CHARGED TO PATIENTS	890,092	2,365,568	0.376270		73.00
74.00	RENAL DIALYSIS	0	0	0.000000		74.00
75.00	ASC (NON-DISTINCT PART)	0	0	0.000000		75.00
OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	0.000000		88.00
91.00	EMERGENCY	3,384,184	8,075,819	0.419051		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	359,352	252,068	1.425615		92.00
93.00	FAMILY PRACTICE	0	0	0.000000		93.00
SPECIAL PURPOSE COST CENTERS						
115.00	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0.000000		115.00
116.00	HOSPICE	0	0	0.000000		116.00
200.00	Subtotal (sum of lines 50 thru 199)	12,920,348	0			200.00
201.00	Less Observation Beds	359,352	0			201.00
202.00	Total (line 200 minus line 201)	12,560,996	87,204,249			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 151303

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

Worksheet D
Part II
Date/Time Prepared:
1/27/2012 9:36 am

Cost Center Description		Title XVIII			Hospital	Cost
		Capital Related Cost (from wkst. B, Part II, col. 26)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)
		1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	116,057	5,922,489	0.019596	28,545	559
51.00	RECOVERY ROOM	0	0	0.000000	0	0
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0
53.00	ANESTHESIOLOGY	0	0	0.000000	0	0
54.00	RADIOLOGY - DIAGNOSTIC	125,994	13,710,693	0.009189	155,310	1,427
55.00	RADIOLOGY - THERAPEUTIC	0	0	0.000000	0	0
56.00	RADIOISOTOPE	0	0	0.000000	0	0
57.00	CT SCAN	0	0	0.000000	0	0
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0
59.00	CARDIAC CATHETERIZATION	0	0	0.000000	0	0
60.00	LABORATORY	44,076	8,992,941	0.004901	235,168	1,153
60.01	BLOOD LABORATORY	0	0	0.000000	0	0
61.00	PBP CLINICAL LAB. SERVICE-PRGM. ONLY	0	0	0.000000	0	0
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.000000	0	0
63.00	BLOOD STORING, PROCESSING, & TRANS.	0	0	0.000000	0	0
64.00	INTRAVENOUS THERAPY	0	0	0.000000	0	0
65.00	RESPIRATORY THERAPY	527	248,977	0.002117	110,915	235
66.00	PHYSICAL THERAPY	21,167	1,278,329	0.016558	49,102	813
67.00	OCCUPATIONAL THERAPY	266	122,802	0.002166	12,502	27
68.00	SPEECH PATHOLOGY	26	10,727	0.002424	2,268	5
69.00	ELECTROCARDIOLOGY	2,552	365,237	0.006987	74,077	518
70.00	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	10,180	1,291,261	0.007884	152,657	1,204
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	930	226,227	0.004111	0	0
73.00	DRUGS CHARGED TO PATIENTS	14,747	2,365,568	0.006234	398,168	2,482
74.00	RENAL DIALYSIS	0	0	0.000000	0	0
75.00	ASC (NON-DISTINCT PART)	0	0	0.000000	0	0
OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0	0.000000	0	0
91.00	EMERGENCY	77,335	8,075,819	0.009576	0	0
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	252,068	0.000000	0	0
93.00	FAMILY PRACTICE	0	0	0.000000	0	0
200.00	Total (lines 50-199)	413,857	42,863,138		1,218,712	8,423

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151303

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

Worksheet D
Part IV
Date/Time Prepared:
1/27/2012 9:36 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	
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	0	0	0	0	50.00
51.00 RECOVERY ROOM	0	0	0	0	0	51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 RADIOLOGY - DIAGNOSTIC	0	0	0	0	0	54.00
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. SERVICE-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
72.00 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00 RENAL DIALYSIS	0	0	0	0	0	74.00
75.00 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00 EMERGENCY	0	0	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00 FAMILY PRACTICE	0	0	0	0	0	93.00
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: 151303

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

Worksheet D
Part IV
Date/Time Prepared:
1/27/2012 9:36 am

Cost Center Description	Title XVIII			Hospital		Cost
	Total	Total Charges	Ratio of Cost	Outpatient	Inpatient	
	Outpatient Cost (sum of col. 2, 3 and 4)	(from wkst. C, Part I, col. 8)	to Charges (col. 5 ÷ col. 7)	Ratio of Cost to Charges (col. 6 ÷ col. 7)	Program Charges	
6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	5,922,489	0.000000	0.000000	28,545	50.00
51.00 RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0	52.00
53.00 ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00 RADIOLOGY - DIAGNOSTIC	0	13,710,693	0.000000	0.000000	155,310	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	8,992,941	0.000000	0.000000	235,168	60.00
60.01 BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
61.00 PBP CLINICAL LAB. SERVICE-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	248,977	0.000000	0.000000	110,915	65.00
66.00 PHYSICAL THERAPY	0	1,278,329	0.000000	0.000000	49,102	66.00
67.00 OCCUPATIONAL THERAPY	0	122,802	0.000000	0.000000	12,502	67.00
68.00 SPEECH PATHOLOGY	0	10,727	0.000000	0.000000	2,268	68.00
69.00 ELECTROCARDIOLOGY	0	365,237	0.000000	0.000000	74,077	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,291,261	0.000000	0.000000	152,657	71.00
72.00 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	226,227	0.000000	0.000000	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	2,365,568	0.000000	0.000000	398,168	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
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
91.00 EMERGENCY	0	8,075,819	0.000000	0.000000	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	252,068	0.000000	0.000000	0	92.00
93.00 FAMILY PRACTICE	0	0	0.000000	0.000000	0	93.00
200.00 Total (lines 50-199)	0	42,863,138			1,218,712	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151303

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

Worksheet D
Part IV
Date/Time Prepared:
1/27/2012 9:36 am

Cost Center Description	Title XVIII			Hospital	Cost	
	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
	11.00	12.00	13.00	21.00	22.00	
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	0	0	0	0	50.00
51.00 RECOVERY ROOM	0	0	0	0	0	51.00
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. SERVICE-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
72.00 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00 RENAL DIALYSIS	0	0	0	0	0	74.00
75.00 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00 EMERGENCY	0	0	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00 FAMILY PRACTICE	0	0	0	0	0	93.00
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: 151303

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

Worksheet D
Part IV
Date/Time Prepared:
1/27/2012 9:36 am

Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	Title XVIII	Hospital	Cost
		23.00	24.00			
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	0			50.00
51.00	RECOVERY ROOM	0	0			51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0			52.00
53.00	ANESTHESIOLOGY	0	0			53.00
54.00	RADIOLOGY - DIAGNOSTIC	0	0			54.00
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. SERVICE-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
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0			72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0			73.00
74.00	RENAL DIALYSIS	0	0			74.00
75.00	ASC (NON-DISTINCT PART)	0	0			75.00
OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0			88.00
91.00	EMERGENCY	0	0			91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0			92.00
93.00	FAMILY PRACTICE	0	0			93.00
200.00	Total (lines 50-199)	0	0			200.00

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Cost
		PPS Reimbursed Services (see instructions)	Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)	
		1.00	2.00	3.00	
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	0.282379	0	1,799,964	0	50.00
51.00 RECOVERY ROOM	0.000000	0	0	0	51.00
52.00 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	52.00
53.00 ANESTHESIOLOGY	0.000000	0	0	0	53.00
54.00 RADIOLOGY - DIAGNOSTIC	0.236833	0	2,874,457	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	0.241054	0	2,725,819	0	60.00
60.01 BLOOD LABORATORY	0.000000	0	0	0	60.01
61.00 PBP CLINICAL LAB. SERVICE-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	0.118605	0	16,120	0	65.00
66.00 PHYSICAL THERAPY	0.259983	0	225,487	0	66.00
67.00 OCCUPATIONAL THERAPY	0.267211	0	13,110	0	67.00
68.00 SPEECH PATHOLOGY	0.336627	0	3,726	0	68.00
69.00 ELECTROCARDIOLOGY	0.137560	0	224,179	0	69.00
70.00 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.470689	0	255,638	0	71.00
72.00 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.632431	0	155,132	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0.376270	0	434,860	528	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
OUTPATIENT SERVICE COST CENTERS					
88.00 RURAL HEALTH CLINIC	0.000000	0	0	0	88.00
91.00 EMERGENCY	0.419051	0	1,747,170	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	1.421501	0	67,776	0	92.00
93.00 FAMILY PRACTICE	0.000000	0	0	0	93.00
200.00 Subtotal (see instructions)		0	10,543,438	528	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	10,543,438	528	202.00

Cost Center Description	Title XVIII			Hospital	Cost
	Costs				
	PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)		
	5.00	6.00	7.00		
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	0	508,272	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	680,766	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	657,070	0		60.00
60.01 BLOOD LABORATORY	0	0	0		60.01
61.00 PBP CLINICAL LAB. SERVICE-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	1,912	0		65.00
66.00 PHYSICAL THERAPY	0	58,623	0		66.00
67.00 OCCUPATIONAL THERAPY	0	3,503	0		67.00
68.00 SPEECH PATHOLOGY	0	1,254	0		68.00
69.00 ELECTROCARDIOLOGY	0	30,838	0		69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	120,326	0		71.00
72.00 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	98,110	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	0	163,625	199		73.00
74.00 RENAL DIALYSIS	0	0	0		74.00
75.00 ASC (NON-DISTINCT PART)	0	0	0		75.00
OUTPATIENT SERVICE COST CENTERS					
88.00 RURAL HEALTH CLINIC	0	0	0		88.00
91.00 EMERGENCY	0	732,153	0		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	96,344	0		92.00
93.00 FAMILY PRACTICE	0	0	0		93.00
200.00 Subtotal (see instructions)	0	3,152,796	199		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges		0			201.00
202.00 Net Charges (line 200 +/- line 201)	0	3,152,796	199		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151303

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

Worksheet D
Part V
Date/Time Prepared:
1/27/2012 9:36 am

Component CCN: 152303

Title XVIII Swing Beds - SNF Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Cost
		PPS Reimbursed Services (see instructions)	Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)	
	1.00	2.00	3.00	4.00	
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	0.282379	0	0	0	50.00
51.00 RECOVERY ROOM	0.000000	0	0	0	51.00
52.00 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	52.00
53.00 ANESTHESIOLOGY	0.000000	0	0	0	53.00
54.00 RADIOLOGY - DIAGNOSTIC	0.236833	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	0.241054	0	0	0	60.00
60.01 BLOOD LABORATORY	0.000000	0	0	0	60.01
61.00 PBP CLINICAL LAB. SERVICE-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	0.118605	0	0	0	65.00
66.00 PHYSICAL THERAPY	0.259983	0	0	0	66.00
67.00 OCCUPATIONAL THERAPY	0.267211	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0.336627	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	0.137560	0	0	0	69.00
70.00 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.470689	0	0	0	71.00
72.00 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.632431	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0.376270	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
OUTPATIENT SERVICE COST CENTERS					
88.00 RURAL HEALTH CLINIC	0.000000				88.00
91.00 EMERGENCY	0.419051	0	0	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	1.421501	0	0	0	92.00
93.00 FAMILY PRACTICE	0.000000	0	0	0	93.00
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: 151303

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

Worksheet D
Part V
Date/Time Prepared:
1/27/2012 9:36 am

Component CCN: 152303

Title XVIII

Swing Beds - SNF

Cost

Cost Center Description	Costs				
	PPS Services (see instructions)	Cost Services Subject To Ded. & Coins. (see instructions)	Cost Services Not Subject To Ded. & Coins. (see instructions)		
	5.00	6.00	7.00		
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	0	0	0		50.00
51.00 RECOVERY ROOM	0	0	0		51.00
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. SERVICE-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
72.00 IMPLANTABLE DEVICES CHARGED TO PATIENTS	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
OUTPATIENT SERVICE COST CENTERS					
88.00 RURAL HEALTH CLINIC	0	0	0		88.00
91.00 EMERGENCY	0	0	0		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
93.00 FAMILY PRACTICE	0	0	0		93.00
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: 151303

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

Worksheet D
Part I
Date/Time Prepared:
1/27/2012 9:36 am

Cost Center Description	Title XIX			Hospital	Cost	
	Capital Related Cost (from wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
	1:00	2:00	3:00	4:00	5:00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	110,712	34,101	76,611	1,303	58.80	30.00
31.00 INTENSIVE CARE UNIT	0		0	0	0.00	31.00
200.00 Total (lines 30-199)	110,712		76,611	1,303		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 151303

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

Worksheet D
Part I
Date/Time Prepared:
1/27/2012 9:36 am

Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	Title XIX	Hospital	Cost
		6.00	7.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	76	4,469			30.00
31.00	INTENSIVE CARE UNIT	0	0			31.00
200.00	Total (lines 30-199)	76	4,469			200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 151303

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

Worksheet D
Part II
Date/Time Prepared:
1/27/2012 9:36 am

Cost Center Description	Title XIX			Hospital	Cost
	Capital Related Cost (from wkst. B, Part II, col. 26)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)
	1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	116,057	5,922,489	0.019596	0	0 50.00
51.00 RECOVERY ROOM	0	0	0.000000	0	0 51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0 52.00
53.00 ANESTHESIOLOGY	0	0	0.000000	0	0 53.00
54.00 RADIOLOGY - DIAGNOSTIC	125,994	13,710,693	0.009189	12,059	111 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	44,076	8,992,941	0.004901	22,817	112 60.00
60.01 BLOOD LABORATORY	0	0	0.000000	0	0 60.01
61.00 PBP CLINICAL LAB. SERVICE-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	527	248,977	0.002117	7,961	17 65.00
66.00 PHYSICAL THERAPY	21,167	1,278,329	0.016558	1,120	19 66.00
67.00 OCCUPATIONAL THERAPY	266	122,802	0.002166	825	2 67.00
68.00 SPEECH PATHOLOGY	26	10,727	0.002424	0	0 68.00
69.00 ELECTROCARDIOLOGY	2,552	365,237	0.006987	696	5 69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0 70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	10,180	1,291,261	0.007884	0	0 71.00
72.00 IMPLANTABLE DEVICES CHARGED TO PATIENTS	930	226,227	0.004111	0	0 72.00
73.00 DRUGS CHARGED TO PATIENTS	14,747	2,365,568	0.006234	25,417	158 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
OUTPATIENT SERVICE COST CENTERS					
88.00 RURAL HEALTH CLINIC	0	0	0.000000	0	0 88.00
91.00 EMERGENCY	77,335	8,075,819	0.009576	504,693	4,833 91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	252,068	0.000000	0	0 92.00
93.00 FAMILY PRACTICE	0	0	0.000000	0	0 93.00
200.00 Total (lines 50-199)	413,857	42,863,138		575,588	5,257 200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 151303		Period: From 07/01/2010 To 06/30/2011		Worksheet D Part III Date/Time Prepared: 1/27/2012 9:36 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		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
200.00	Total (lines 30-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 151303		Period: From 07/01/2010 To 06/30/2011		Worksheet D Part III Date/Time Prepared: 1/27/2012 9:36 am	
Cost Center Description		Total Patient Days	Per Diem (col. 5 - col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. Nursing School	Cost
		6.00	7.00	8.00	9.00	11.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	1,303	0.00	76	0	0	30.00
31.00	INTENSIVE CARE UNIT	0	0.00	0	0	0	31.00
200.00	Total (lines 30-199)	1,303		76	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 151303		Period: From 07/01/2010 To 06/30/2011	Worksheet D Part III Date/Time Prepared: 1/27/2012 9:36 am
Title XIX			Hospital		Cost
Cost Center Description	PSA Adj. Allied Health Cost	PSA Adj. All Other Medical Education Cost			
	12.00	13.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS	0	0		30.00
31.00	INTENSIVE CARE UNIT	0	0		31.00
200.00	Total (lines 30-199)	0	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151303

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

Worksheet D
Part IV
Date/Time Prepared:
1/27/2012 9:36 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		
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	0	0	0	0	0	50.00
51.00	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY - DIAGNOSTIC	0	0	0	0	0	54.00
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. SERVICE-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
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	EMERGENCY	0	0	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	FAMILY PRACTICE	0	0	0	0	0	93.00
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: 151303

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

Worksheet D
Part IV
Date/Time Prepared:
1/27/2012 9:36 am

Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Title XIX		Hospital		Cost
		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	
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	5,922,489	0.000000	0.000000	0	50.00
51.00 RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0	52.00
53.00 ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00 RADIOLOGY - DIAGNOSTIC	0	13,710,693	0.000000	0.000000	12,059	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	8,992,941	0.000000	0.000000	22,817	60.00
60.01 BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
61.00 PBP CLINICAL LAB. SERVICE-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	248,977	0.000000	0.000000	7,961	65.00
66.00 PHYSICAL THERAPY	0	1,278,329	0.000000	0.000000	1,120	66.00
67.00 OCCUPATIONAL THERAPY	0	122,802	0.000000	0.000000	825	67.00
68.00 SPEECH PATHOLOGY	0	10,727	0.000000	0.000000	0	68.00
69.00 ELECTROCARDIOLOGY	0	365,237	0.000000	0.000000	696	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,291,261	0.000000	0.000000	0	71.00
72.00 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	226,227	0.000000	0.000000	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	2,365,568	0.000000	0.000000	25,417	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
OUTPATIENT SERVICE COST CENTERS						
88.00 RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
91.00 EMERGENCY	0	8,075,819	0.000000	0.000000	504,693	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	252,068	0.000000	0.000000	0	92.00
93.00 FAMILY PRACTICE	0	0	0.000000	0.000000	0	93.00
200.00 Total (lines 50-199)	0	42,863,138			575,588	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151303

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

Worksheet D
Part IV
Date/Time Prepared:
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Cost Center Description	Title XIX			Hospital		Cost	
	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School		
	11.00	12.00	13.00	21.00	22.00		
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	0	0	0	0	0	50.00
51.00	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	RADIOLOGY - DIAGNOSTIC	0	0	0	0	0	54.00
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. SERVICE-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
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS							
88.00	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	EMERGENCY	0	0	0	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	FAMILY PRACTICE	0	0	0	0	0	93.00
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: 151303

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

Worksheet D
Part IV
Date/Time Prepared:
1/27/2012 9:36 am

Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	Title XIX	Hospital	Cost
		23.00	24.00			
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	0			50.00
51.00	RECOVERY ROOM	0	0			51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0			52.00
53.00	ANESTHESIOLOGY	0	0			53.00
54.00	RADIOLOGY - DIAGNOSTIC	0	0			54.00
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. SERVICE-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
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0			72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0			73.00
74.00	RENAL DIALYSIS	0	0			74.00
75.00	ASC (NON-DISTINCT PART)	0	0			75.00
OUTPATIENT SERVICE COST CENTERS						
88.00	RURAL HEALTH CLINIC	0	0			88.00
91.00	EMERGENCY	0	0			91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	0	0			92.00
93.00	FAMILY PRACTICE	0	0			93.00
200.00	Total (lines 50-199)	0	0			200.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151303

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

Worksheet D-1

Date/Time Prepared:
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Cost Center Description		Title XVIII	Hospital	Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			1,934 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			1,303 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)			1,303 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			0 5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			580 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			26 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)			25 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			675 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)			229 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)			351 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0 14.00
15.00	Total nursery days (title V or XIX only)			0 15.00
16.00	Nursery days (title V or XIX only)			0 16.00
SWING-BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			0.00 17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			0.00 18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			152.53 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			152.53 20.00
21.00	Total general inpatient routine service cost (see instructions)			2,695,855 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)			3,966 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)			3,813 25.00
26.00	Total swing-bed cost (see instructions)			835,758 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			1,860,097 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)			1,383,516 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			1,383,516 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			1.344471 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)			1,061.79 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)			1,860,097 37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			1,427.55 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			963,596 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)			963,596 41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151303

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

Worksheet D-1

Date/Time Prepared:
1/27/2012 9:36 am

Cost Center Description	Title XVIII			Hospital	Cost
	Total	Total	Average Per	Program Days	Program Cost
	Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)		(col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00 NURSERY (title V & XIX only)					42.00
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	43.00
44.00 CORONARY CARE UNIT					44.00
45.00 BURN INTENSIVE CARE UNIT					45.00
46.00 SURGICAL INTENSIVE CARE UNIT					46.00
47.00 OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description					
					1.00
48.00 Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					363,420 48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,327,016 49.00
PASS THROUGH COST ADJUSTMENTS					
50.00 Pass through costs applicable to Program inpatient routine services (from wkst. D, sum of Parts I and III)					0 50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from wkst. D, sum of Parts II and IV)					0 51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					0 52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0 53.00
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00 Program discharges					0 54.00
55.00 Target amount per discharge					0.00 55.00
56.00 Target amount (line 54 x line 55)					0 56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0 57.00
58.00 Bonus payment (see instructions)					0 58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00 59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00 60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0 61.00
62.00 Relief payment (see instructions)					0 62.00
63.00 Allowable inpatient cost plus incentive payment (see instructions)					0 63.00
PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					326,909 64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					501,070 65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					827,979 66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0 67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0 68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0 69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY					
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)					70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00 Program routine service cost (line 9 x line 71)					72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from worksheet B, Part II, column 26, line 45)					75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00 Program capital-related costs (line 9 x line 76)					77.00
78.00 Inpatient routine service cost (line 74 minus line 77)					78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00 Inpatient routine service cost per diem limitation					81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00 Reasonable inpatient routine service costs (see instructions)					83.00
84.00 Program inpatient ancillary services (see instructions)					84.00
85.00 Utilization review - physician compensation (see instructions)					85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST					
87.00 Total observation bed days (see instructions)					251 87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,427.55 88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					358,315 89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151303

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

Worksheet D-1
Date/Time Prepared:
1/27/2012 9:36 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	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	0	0	0.000000	0	0	90.00
91.00 Nursing School cost	0	0	0.000000	0	0	91.00
92.00 Allied health cost	0	0	0.000000	0	0	92.00
93.00 All other Medical Education	0	0	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151303

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

Worksheet D-1

Date/Time Prepared:
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Cost Center Description		Title XIX	Hospital	Cost
PART I - ALL PROVIDER COMPONENTS				1.00
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			1,934 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			1,303 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)			1,303 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			0 5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			580 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			0 7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			51 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			76 9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			0 10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0 14.00
15.00	Total nursery days (title V or XIX only)			0 15.00
16.00	Nursery days (title V or XIX only)			0 16.00
SWING-BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			0.00 17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			0.00 18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			0.00 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			0.00 20.00
21.00	Total general inpatient routine service cost (see instructions)			2,695,855 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)			830,374 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			1,865,481 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)			1,383,516 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			1,383,516 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 3)			1.348362 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)			1,061.79 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)			1,865,481 37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			1,431.68 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			108,808 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)			108,808 41.00

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COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151303

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

Worksheet D-1

Date/Time Prepared:
1/27/2012 9:36 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)
	1.00	2.00	3.00	4.00	5.00
42.00 NURSERY (title V & XIX only)					42.00
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	43.00
44.00 CORONARY CARE UNIT					44.00
45.00 BURN INTENSIVE CARE UNIT					45.00
46.00 SURGICAL INTENSIVE CARE UNIT					46.00
47.00 OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description					1.00
48.00 Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					230,963 48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					339,771 49.00
PASS THROUGH COST ADJUSTMENTS					
50.00 Pass through costs applicable to Program inpatient routine services (from wkst. D, sum of Parts I and III)					0 50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from wkst. D, sum of Parts II and IV)					0 51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					0 52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0 53.00
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00 Program discharges					0 54.00
55.00 Target amount per discharge					0.00 55.00
56.00 Target amount (line 54 x line 55)					0 56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0 57.00
58.00 Bonus payment (see instructions)					0 58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00 59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00 60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0 61.00
62.00 Relief payment (see instructions)					0 62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0 63.00
PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0 64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0 65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0 66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0 67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0 68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0 69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY					
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)					70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00 Program routine service cost (line 9 x line 71)					72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from worksheet B, Part II, column 26, line 45)					75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00 Program capital-related costs (line 9 x line 76)					77.00
78.00 Inpatient routine service cost (line 74 minus line 77)					78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00 Inpatient routine service cost per diem limitation					81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00 Reasonable inpatient routine service costs (see instructions)					83.00
84.00 Program inpatient ancillary services (see instructions)					84.00
85.00 Utilization review - physician compensation (see instructions)					85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00 Total observation bed days (see instructions)					251 87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,431.68 88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					359,352 89.00

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COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151303

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

Worksheet D-1

Date/Time Prepared:
1/27/2012 9:36 am

Cost Center Description	Cost	Title XIX		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	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	0	0	0.000000	0	0	90.00
91.00 Nursing School cost	0	0	0.000000	0	0	91.00
92.00 Allied health cost	0	0	0.000000	0	0	92.00
93.00 All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 151303

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

Worksheet D-3

Date/Time Prepared:
1/27/2012 9:36 am

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	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS		618,973		30.00
31.00	INTENSIVE CARE UNIT		0		31.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.282379	28,545	8,061	50.00
51.00	RECOVERY ROOM	0.000000	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	RADIOLOGY - DIAGNOSTIC	0.236833	155,310	36,783	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	0.241054	235,168	56,688	60.00
60.01	BLOOD LABORATORY	0.000000	0	0	60.01
61.00	PBP CLINICAL LAB. SERVICE-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	0.118605	110,915	13,155	65.00
66.00	PHYSICAL THERAPY	0.259983	49,102	12,766	66.00
67.00	OCCUPATIONAL THERAPY	0.267211	12,502	3,341	67.00
68.00	SPEECH PATHOLOGY	0.336627	2,268	763	68.00
69.00	ELECTROCARDIOLOGY	0.137560	74,077	10,190	69.00
70.00	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.470689	152,657	71,854	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.632431	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.376270	398,168	149,819	73.00
74.00	RENAL DIALYSIS	0.000000	0	0	74.00
75.00	ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	0.000000			88.00
91.00	EMERGENCY	0.419051	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.421501	0	0	92.00
93.00	FAMILY PRACTICE	0.000000	0	0	93.00
200.00	Total (sum of lines 50-94 and 96-98)		1,218,712	363,420	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net Charges (line 200 minus line 201)		1,218,712		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 151303	Period: From 07/01/2010 To 06/30/2011	worksheet D-3
	Component CCN: 15Z303		Date/Time Prepared: 1/27/2012 9:36 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	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS		0		30.00
31.00	INTENSIVE CARE UNIT		0		31.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.282379	4,640	1,310	50.00
51.00	RECOVERY ROOM	0.000000	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	RADIOLOGY - DIAGNOSTIC	0.236833	27,044	6,405	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	0.241054	66,314	15,985	60.00
60.01	BLOOD LABORATORY	0.000000	0	0	60.01
61.00	PBP CLINICAL LAB. SERVICE-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	0.118605	78,090	9,262	65.00
66.00	PHYSICAL THERAPY	0.259983	136,598	35,513	66.00
67.00	OCCUPATIONAL THERAPY	0.267211	46,669	12,470	67.00
68.00	SPEECH PATHOLOGY	0.336627	2,771	933	68.00
69.00	ELECTROCARDIOLOGY	0.137560	5,353	736	69.00
70.00	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.470689	96,449	45,397	71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.632431	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.376270	235,172	88,488	73.00
74.00	RENAL DIALYSIS	0.000000	0	0	74.00
75.00	ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
OUTPATIENT SERVICE COST CENTERS					
88.00	RURAL HEALTH CLINIC	0.000000			88.00
91.00	EMERGENCY	0.419051	0	0	91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	1.421501	0	0	92.00
93.00	FAMILY PRACTICE	0.000000	0	0	93.00
200.00	Total (sum of lines 50-94 and 96-98)		699,100	216,499	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net Charges (line 200 minus line 201)		699,100		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 151303

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

Worksheet D-3

Date/Time Prepared:
1/27/2012 9:36 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		
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 ADULTS & PEDIATRICS		55,957			30.00
31.00 INTENSIVE CARE UNIT		0			31.00
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	0.282379	0	0	0	50.00
51.00 RECOVERY ROOM	0.000000	0	0	0	51.00
52.00 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	52.00
53.00 ANESTHESIOLOGY	0.000000	0	0	0	53.00
54.00 RADIOLOGY - DIAGNOSTIC	0.236833	12,059	2,856	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	0.241054	22,817	5,500	0	60.00
60.01 BLOOD LABORATORY	0.000000	0	0	0	60.01
61.00 PBP CLINICAL LAB. SERVICE-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	0.118605	7,961	944	0	65.00
66.00 PHYSICAL THERAPY	0.259983	1,120	291	0	66.00
67.00 OCCUPATIONAL THERAPY	0.267211	825	220	0	67.00
68.00 SPEECH PATHOLOGY	0.336627	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	0.137560	696	96	0	69.00
70.00 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.470689	0	0	0	71.00
72.00 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.632431	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0.376270	25,417	9,564	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
OUTPATIENT SERVICE COST CENTERS					
88.00 RURAL HEALTH CLINIC	0.000000	0	0	0	88.00
91.00 EMERGENCY	0.419051	504,693	211,492	0	91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	1.425615	0	0	0	92.00
93.00 FAMILY PRACTICE	0.000000	0	0	0	93.00
200.00 Total (sum of lines 50-94 and 96-98)		575,588	230,963	0	200.00
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	0	201.00
202.00 Net Charges (line 200 minus line 201)		575,588		0	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 151303

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

Worksheet E
Part B
Date/Time Prepared:
1/27/2012 9:36 am

		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		3,152,995	1.00
2.00	Medical and other services reimbursed under OPSS (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)		3,152,995	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from worksheet D-4, Part III, line 69, col. 4)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a 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)		3,184,525	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		0	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		38,773	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		1,551,303	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)		1,594,449	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)		1,594,449	30.00
31.00	Primary payer payments		814	31.00
32.00	Subtotal (line 30 minus line 31)		1,593,635	32.00
ALLOWABLE BAD DEBTS: (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from worksheet I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		457,623	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		457,623	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		391,909	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)		2,051,258	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)		2,051,258	40.00
41.00	Interim payments		2,289,350	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)		-238,092	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151303	Period: From 07/01/2010 To 06/30/2011	Worksheet E Part B Date/Time Prepared: 1/27/2012 9:36 am
		Title XVIII	Hospital	Cost
				Overrides
				1.00
WORKSHEET OVERRIDE VALUES				
112.00	override of Ancillary service charges (line 12)			0112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151303

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

Worksheet E-1
Part I
Date/Time Prepared:
1/27/2012 9:36 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		1,195,878		2,483,932		1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0		2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER	05/19/2011	235,342		0		3.01
3.02			0		0		3.02
3.03			0		0		3.03
3.04			0		0		3.04
3.05			0		0		3.05
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM	02/10/2011	28,162	02/10/2011	31,979		3.50
3.51			0	05/19/2011	162,603		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)		207,180		-194,582		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)		1,403,058		2,289,350		4.00
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						5.00
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0		5.01
5.02			0		0		5.02
5.03			0		0		5.03
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0		5.50
5.51			0		0		5.51
5.52			0		0		5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0		5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)						6.00
6.01	SETTLEMENT TO PROVIDER		0		0		6.01
6.02	SETTLEMENT TO PROGRAM		224,972		238,092		6.02
7.00	Total Medicare program liability (see instructions)		1,178,086		2,051,258		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: 151303

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

Worksheet E-1
Part I
Date/Time Prepared:
1/27/2012 9:36 am

Component CCN: 152303

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					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		1,096,414			0 2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	05/19/2011	112,424			0 3.01
3.02			0			0 3.02
3.03			0			0 3.03
3.04			0			0 3.04
3.05			0			0 3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM	02/10/2011	22,090			0 3.50
3.51			0			0 3.51
3.52			0			0 3.52
3.53			0			0 3.53
3.54			0			0 3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		90,334			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)		1,186,748			0 4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0			0 5.01
5.02			0			0 5.02
5.03			0			0 5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0			0 5.50
5.51			0			0 5.51
5.52			0			0 5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0			0 5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0			0 6.01
6.02	SETTLEMENT TO PROGRAM		140,512			0 6.02
7.00	Total Medicare program liability (see instructions)		1,046,236			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: 151303

Period: From 07/01/2010

Worksheet E-2

Component CCN: 15Z303

To 06/30/2011

Date/Time Prepared: 1/27/2012 9:36 am

		Title XVIII		Swing Beds - SNF		Cost	
		Part A		Part B			
		1.00		2.00			
COMPUTATION OF NET COST OF COVERED SERVICES							
1.00	Inpatient routine services - swing bed-SNF (see instructions)	836,259		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)	218,664		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	580		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)	1,054,923		0		8.00	
9.00	Primary payer payments (see instructions)	0		0		9.00	
10.00	Subtotal (line 8 minus line 9)	1,054,923		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)	1,054,923		0		12.00	
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	8,687		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)	1,046,236		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)	1,046,236		0		19.00	
20.00	Interim payments	1,186,748		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)	-140,512		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: 151303	Period: From 07/01/2010 To 06/30/2011	Worksheet E-3 Part V Date/Time Prepared: 1/27/2012 9:36 am
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	Title XVIII	Hospital	Cost	
			1.00	
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHS)				
1.00	Inpatient services		1,327,016	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)		1,327,016	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 5 less line 6) . For CAH (see instructions)		1,340,286	6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
7.00	Routine service charges		0	7.00
8.00	Ancillary service charges		0	8.00
9.00	Organ acquisition charges, net of revenue		0	9.00
10.00	Total reasonable charges		0	10.00
Customary charges				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)		0.000000	13.00
14.00	Total customary charges (see instructions)		0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)		0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)		0	16.00
17.00	Cost of teaching physicians (from worksheet D-5, Part II, column 3, line 20) (see instructions)		0	17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from worksheet E-4, line 49)		0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)		1,340,286	19.00
20.00	Deductibles (exclude professional component)		201,226	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)		1,139,060	22.00
23.00	Coinsurance		275	23.00
24.00	Subtotal (line 22 minus line 23)		1,138,785	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		39,301	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		39,301	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		34,560	27.00
28.00	Subtotal (sum of lines 24 and 25 or 26(line 26 hospital and subprovider only))		1,178,086	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)		1,178,086	30.00
31.00	Interim payments		1,403,058	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)		-224,972	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 151303

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

Worksheet E-3
Part VII
Date/Time Prepared:
1/27/2012 9:36 am

	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		339,771	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)		339,771	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)		339,771	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges		0	8.00
9.00	Ancillary service charges		575,588	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)		575,588	12.00
CUSTOMARY CHRGES				
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	15.00
16.00	Total customary charges (see instructions)		575,588	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 7) (see instructions)		235,817	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)		339,771	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)		339,771	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)		339,771	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)		339,771	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	37.00
38.00	Subtotal (line 36 ± line 37)		339,771	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)		339,771	40.00
41.00	Interim payments		339,771	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: 151303

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

Worksheet G

Date/Time Prepared: 1/27/2012 9:36 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	2,563,089	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	6,847,980	0	0	0	4.00
5.00	Other receivable	668	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-4,862,899	0	0	0	6.00
7.00	Inventory	178,085	0	0	0	7.00
8.00	Prepaid expenses	90,351	0	0	0	8.00
9.00	Other current assets	-12,721	193,259	0	0	9.00
10.00	Due from other funds	-1,093	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	4,803,460	193,259	0	0	11.00
FIXED ASSETS						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	18,099,753	0	0	0	15.00
16.00	Accumulated depreciation	-8,303,272	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	9,796,481	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	1,863,666	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	937,784	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	2,801,450	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	17,401,391	193,259	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	518,527	0	0	0	37.00
38.00	Salaries, wages, and fees payable	836,276	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	78,641	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	507,178	0	0	0	43.00
44.00	Other current liabilities	998,023	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2,938,645	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	10,852,841	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	1,226,258	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	12,079,099	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	15,017,744	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	2,383,647	0	0	0	52.00
53.00	Specific purpose fund	0	193,259	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	2,383,647	193,259	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	17,401,391	193,259	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151303

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

Worksheet G-1

Date/Time Prepared:
1/27/2012 9:36 am

	General Fund		Special Purpose Fund		
	1.00	2.00	3.00	4.00	
1.00 Fund balances at beginning of period		2,529,597		135,685	1.00
2.00 Net income (loss) (from wkst. G-3, line 29)		-1,003,111			2.00
3.00 Total (sum of line 1 and line 2)		1,526,486		135,685	3.00
4.00 CONTRIBUTIONS	0		50,175		4.00
5.00 GRANT REVENUE - FEDERAL	0		134,625		5.00
6.00 OTHER RESTRICTED ACTIVITY	0		338		6.00
7.00 DEFERRED PERSION COSTS ADMINISTERED	407,161		0		7.00
8.00 OTHER CHANGES	450,000		0		8.00
9.00	0		0		9.00
10.00 Total additions (sum of line 4-9)		857,161		185,138	10.00
11.00 Subtotal (line 3 plus line 10)		2,383,647		320,823	11.00
12.00 NET ASSETS RELEASED FROM RESTRICTION	0		127,564		12.00
13.00	0		0		13.00
14.00	0		0		14.00
15.00	0		0		15.00
16.00	0		0		16.00
17.00	0		0		17.00
18.00 Total deductions (sum of lines 12-17)		0		127,564	18.00
19.00 Fund balance at end of period per balance sheet (line 11 minus line 18)		2,383,647		193,259	19.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151303

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

Worksheet G-1

Date/Time Prepared:
1/27/2012 9:36 am

	Endowment Fund		Plant Fund			
	5.00	6.00	7.00	8.00		
1.00						1.00
Fund balances at beginning of period		0		0		
2.00						2.00
Net income (loss) (from Wkst. G-3, line 29)						
3.00		0		0		3.00
Total (sum of line 1 and line 2)						
4.00						4.00
CONTRIBUTIONS	0		0			
5.00						5.00
GRANT REVENUE - FEDERAL	0		0			
6.00						6.00
OTHER RESTRICTED ACTIVITY	0		0			
7.00						7.00
DEFERRED PENSION COSTS ADMINISTERED	0		0			
8.00						8.00
OTHER CHANGES	0		0			
9.00						9.00
	0		0			
10.00		0		0		10.00
Total additions (sum of line 4-9)						
11.00		0		0		11.00
Subtotal (line 3 plus line 10)						
12.00						12.00
NET ASSETS RELEASED FROM RESTRICTION	0		0			
13.00						13.00
	0		0			
14.00						14.00
	0		0			
15.00						15.00
	0		0			
16.00						16.00
	0		0			
17.00						17.00
	0		0			
18.00		0		0		18.00
Total deductions (sum of lines 12-17)						
19.00		0		0		19.00
Fund balance at end of period per balance sheet (line 11 minus line 18)						

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	1,383,516		1,383,516	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	343,995		343,995	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)	1,727,511		1,727,511	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	0		0	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)	1,727,511		1,727,511	17.00
18.00	Ancillary services	4,528,775	0	4,528,775	18.00
19.00	Outpatient services	0	40,498,121	40,498,121	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	25.00
26.00	HOSPICE	0	0	0	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)	6,256,286	40,498,121	46,754,407	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per wkst. A, column 3, line 200)		17,802,988		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)		17,802,988		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 151303

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

Worksheet G-3

Date/Time Prepared:
1/27/2012 9:36 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	46,754,407	1.00
2.00	Less contractual allowances and discounts on patients' accounts	26,266,887	2.00
3.00	Net patient revenues (line 1 minus line 2)	20,487,520	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	17,802,988	4.00
5.00	Net income from service to patients (line 3 minus line 4)	2,684,532	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	196,456	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	25,330	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	11,510	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	1,546	21.00
22.00	Rental of hospital space	356,551	22.00
23.00	Governmental appropriations	0	23.00
24.00	RHC REVENUE	271	24.00
24.01	NET ASSETS RELEASED FROM RESTRICTION	127,564	24.01
24.02	GRANTS / FOUNDATION INCOME	106,620	24.02
24.03	GAIN ON EQUIPMENT SALE	18,192	24.03
24.04	OTHER DIETARY INCOME	8,335	24.04
24.05	MISC REVENUE	23,492	24.05
24.06	UNREALIZED GAIN	134,620	24.06
24.07	OTHER REVENUE	1	24.07
25.00	Total other income (sum of lines 6-24)	1,010,488	25.00
26.00	Total (line 5 plus line 25)	3,695,020	26.00
27.00	BAD DEBTS	4,698,131	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	4,698,131	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-1,003,111	29.00