

**ST. VINCENT SETON SPECIALTY HOSPITAL
INDIANAPOLIS, IN**

**MEDICARE PROVIDER NO. 15-2020
AND MEDICAID AIM NO. 200392020A**

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

JUNE 30, 2011

ST. VINCENT SETON SPECIALTY HOSPITAL
INDIANAPOLIS, IN

MEDICARE PROVIDER NO. 15-2020
AND MEDICAID AIM NO. 200392020A

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Accountants' Disclaimer

Hospital Statements of Reimbursable Costs



Board of Directors
St. Vincent Seton Specialty Hospital
Indianapolis, IN

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

Our compilation was limited to presenting in the form prescribed by the Centers for Medicare and Medicaid Services, information that is the representation of management. We have not audited or reviewed the 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 report is intended to be filed with the Centers for Medicare and Medicaid Services and should not be used for any other purposes.

Bradley Associates

December 28, 2011

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: 152020	Period: From 07/01/2010 To 06/30/2011	Worksheet 5 Parts I-III Date/Time Prepared: 12/29/2011 9:41 am
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PART I - COST REPORT STATUS

Provider use only

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

Contractor use only

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

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

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

Date: 12/29/2011 Time: 9:41 am

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 SETON SPECIALTY HOSP INDY 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: 12/29/2011 Time: 9:41 am
 HIXusB: rtypG:.QySHcvzjuwpmczG0
 :QF:u03Yjuj.30:jx8861su3h0xIgj
 lKU70loxpZ0NXZHB
 PI: Date: 12/29/2011 Time: 9:41 am
 Br9Q8j0apbEL0w3i30oSGTD8yjpR00
 GcRJ.03LZxJkwyYOMFsbkUb.8v145N
 lg9LJGcodi0hc:ms

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

 Title

 Date

	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	457,469	0	0	0	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
4.00 SUBPROVIDER I	0	0	0	0	0	4.00
5.00 Swing bed - SNF	0	0	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
7.00 Skilled Nursing Facility	0	0	0	0	0	7.00
8.00 Nursing Facility	0	0	0	0	0	8.00
9.00 HOME HEALTH AGENCY I	0	0	0	0	0	9.00
10.00 RURAL HEALTH CLINIC I	0	0	0	0	0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0	0	0	0	0	11.00
12.00 CMHC I	0	0	0	0	0	12.00
200.00 Total	0	457,469	0	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: 152020	Period: From 07/01/2010 To 06/30/2011	Worksheet S-2 Part I Date/Time Prepared: 12/28/2011 4:43 pm
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		1.00	2.00	3.00	4.00				
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 8050 TOWNSHIP LINE ROAD	PO Box:	Zip Code: 46260		County: MARION				
2.00	City: INDIANAPOLIS	State: IN							
		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 SETON SPECIALTY HOSP INDY	152020	26900	2	02/08/2003	N	P	O
4.00	Subprovider - IPF								
5.00	Subprovider - IRF								
6.00	Subprovider - (Other)								
7.00	Swing Beds - SNF						N	N	N
8.00	Swing Beds - NF						N		N
9.00	Hospital-Based SNF								
10.00	Hospital-Based NF								
11.00	Hospital-Based OLTC								
12.00	Hospital-Based HHA								
13.00	Separately Certified ASC								
14.00	Hospital-Based Hospice								
15.00	Hospital-Based Health Clinic - RHC								
16.00	Hospital-Based Health Clinic - FQHC								
17.00	Hospital-Based (CMHC) 1								
18.00	Renal Dialysis								
19.00	Other								
						From:	To:		
						1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)					07/01/2010	06/30/2011		20.00
21.00	Type of Control (see instructions)					1			21.00
Inpatient: PPS Information									
22.00	Does this facility qualify for and receive disproportionate share hospital payment in accordance with 42 CFR Section §412.106, or low income payment in accordance with 42 CFR Section §412.624(e)(2)? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	N		22.00
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					2	N		23.00
		In-State Medicaid paid days	In-State Medicaid eligible days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible days	Medicaid HMO days	Other Medicaid days		
		1.00	2.00	3.00	4.00	5.00	6.00		
24.00	If line 22 and/or line 45 is "yes", and this provider is an IPPS hospital enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible days in col. 4, Medicaid HMO days in col. 5, and other Medicaid days in col. 6.	0	0	0	0	0	0		
25.00	If this provider is an IRF then enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible days in col. 4, Medicaid HMO days in col. 5, and other Medicaid days in col. 6.	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.								1 26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period? Enter (1) for urban or (2) for rural.								1 27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.								0 35.00
						Beginning:	Ending:		
						1.00	2.00		
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.								36.00
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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 152020	Period: From 07/01/2010 To 06/30/2011	Worksheet S-2 Part I Date/Time Prepared: 12/28/2011 4:43 pm		
		V	XVIII	XIX		
		1.00	2.00	3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00	
46.00	Is this facility eligible for the special exceptions payment pursuant to 42 CFR Section §412.348(g)? If yes, complete Worksheet L, Part III and L-1, Parts I through III	N	N	N	46.00	
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N	47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00	
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.				57.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete worksheet D-5.				58.00	
59.00	Are costs claimed on line 100 of worksheet A? If yes, complete worksheet D-2, Part I.	N			59.00	
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00	
		Y/N	IME Average	Direct GME Average		
		1.00	2.00	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	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
		1.00	2.00	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	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
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
		1.00	2.00	3.00		

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 152020	Period: From 07/01/2010 To 06/30/2011	Worksheet S-2 Part I Date/Time Prepared: 12/28/2011 4:43 pm	
		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 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	
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	
		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		0
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
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		0
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
				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.			Y	
85.00	TEFRA Providers Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N	
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	
		V		XIX	
		1.00		2.00	
90.00	Title V or XIX Inpatient Services 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	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N		Y	
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	
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	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N		N	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.			0.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.			0.00	

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 152020	Period: From 07/01/2010 To 06/30/2011	Worksheet S-2 Part I Date/Time Prepared: 12/28/2011 4:43 pm
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		V	XIX		
		1.00	2.00		
Rural Providers					
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	N		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	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	N	107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00	
		Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.				109.00
				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.		2	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.		250,000	5,000,000	119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 as amended by the Medicaid Extender Act (MMEA) §108? Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with <= 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121? Enter in column 2 "Y" for yes or "N" for no.	N	N	120.00	
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N		121.00	
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00	
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00	
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00	
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00	
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00	
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00	
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00	
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00	
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00	
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		140.00	
		1.00	2.00	3.00	
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.					
141.00	Name: ST. VINCENT HEALTH	Contractor's Name: NGS		Contractor's Number: 00130	
142.00	Street: 10330 N. MERIDIAN ST	PO Box:			
143.00	City: INDIANAPOLIS	State: IN	Zip Code: 46290		
				1.00	
144.00	Are provider based physicians' costs included in worksheet A?	N		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.	Y		145.00	

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 152020	Period: From 07/01/2010 To 06/30/2011	Worksheet S-2 Part II Date/Time Prepared: 12/28/2011 4:43 pm
		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	09/13/2011
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.		N	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	11/09/2011	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		20.00

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HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 152020	Period: From 07/01/2010 To 06/30/2011	Worksheet S-2 Part II Date/Time Prepared: 12/28/2011 4:43 pm
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	Description	Part A		
		Y/N	Date	
	0	1.00	2.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		21.00
				1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)				
Capital Related Cost				
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N		27.00
Interest Expense				
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	Y		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N		31.00
Purchased Services				
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N		33.00
Provider-Based Physicians				
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	N		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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 152020	Period: From 07/01/2010 To 06/30/2011	Worksheet S-2 Part II Date/Time Prepared: 12/28/2011 4:43 pm
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		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	11/09/2011	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: 152020

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

Worksheet S-3
Part I
Date/Time Prepared:
12/28/2011 4:43 pm

Cost Center Description	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	
	Line Number				
	1.00	2.00	3.00	4.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	74	27,010	0.00	1.00
2.00 HMO					2.00
3.00 HMO IPF					3.00
4.00 HMO IRF					4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					5.00
6.00 Hospital Adults & Peds. Swing Bed NF					6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		74	27,010	0.00	7.00
8.00 INTENSIVE CARE UNIT					8.00
9.00 CORONARY CARE UNIT					9.00
10.00 BURN INTENSIVE CARE UNIT					10.00
11.00 SURGICAL INTENSIVE CARE UNIT					11.00
12.00 OTHER SPECIAL CARE (SPECIFY)					12.00
13.00 NURSERY					13.00
14.00 Total (see instructions)		74	27,010	0.00	14.00
15.00 CAH visits					15.00
16.00 SUBPROVIDER - IPF					16.00
17.00 SUBPROVIDER - IRF					17.00
18.00 SUBPROVIDER					18.00
19.00 SKILLED NURSING FACILITY					19.00
20.00 NURSING FACILITY					20.00
21.00 OTHER LONG TERM CARE					21.00
22.00 HOME HEALTH AGENCY					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)					23.00
24.00 HOSPICE					24.00
25.00 CMHC - CMHC					25.00
26.00 RURAL HEALTH CLINIC					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER					26.25
27.00 Total (sum of lines 14-26)		74			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				
	Title V	Title XVIII	Title XIX	Total All Patients	
	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	15,081	882	22,830	1.00
2.00 HMO		1,938	0		2.00
3.00 HMO IPF		0	0		3.00
4.00 HMO IRF		0	0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0	0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0	0	0	0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	0	15,081	882	22,830	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	15,081	882	22,830	14.00
15.00 CAH visits	0	0	0	0	15.00
16.00 SUBPROVIDER - IPF					16.00
17.00 SUBPROVIDER - IRF					17.00
18.00 SUBPROVIDER					18.00
19.00 SKILLED NURSING FACILITY					19.00
20.00 NURSING FACILITY					20.00
21.00 OTHER LONG TERM CARE					21.00
22.00 HOME HEALTH AGENCY					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)					23.00
24.00 HOSPICE					24.00
25.00 CMHC - CMHC					25.00
26.00 RURAL HEALTH CLINIC					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER					26.25
27.00 Total (sum of lines 14-26)					27.00
28.00 Observation Bed Days	0		0	0	28.00
29.00 Ambulance Trips		0			29.00
30.00 Employee discount days (see instruction)				0	30.00
31.00 Employee discount days - IRF				0	31.00
32.00 Labor & delivery days (see instructions)			0	0	32.00
33.00 LTCH non-covered days		0			33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 152020

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

Worksheet S-3
Part I
Date/Time Prepared:
12/28/2011 4:43 pm

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	503	1.00
2.00 HMO					0	2.00
3.00 HMO IPF						3.00
4.00 HMO IRF						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	298.01	0.00	0	503	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)	0.00	298.01	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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 152020

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

Worksheet S-3
Part I
Date/Time Prepared:
12/28/2011 4:43 pm

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)	18	769	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)	18	769	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

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 152020

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

Worksheet A

Date/Time Prepared:
12/28/2011 4:43 pm

Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
	1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS						
1.00 CAP REL COSTS-BLDG & FIXT		1,116,919	1,116,919	-4,506	1,112,413	1.00
2.00 CAP REL COSTS-MVBLE EQUIP		1,440,240	1,440,240	0	1,440,240	2.00
3.00 OTHER CAP REL COSTS		0	0	0	0	3.00
4.00 EMPLOYEE BENEFITS	251,131	5,307,763	5,558,894	0	5,558,894	4.00
5.00 ADMINISTRATIVE & GENERAL	2,779,807	2,154,714	4,934,521	4,506	4,939,027	5.00
6.00 MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00 OPERATION OF PLANT	380,848	643,286	1,024,134	0	1,024,134	7.00
8.00 LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00 HOUSEKEEPING	219,569	248,614	468,183	0	468,183	9.00
10.00 DIETARY	352,525	360,854	713,379	0	713,379	10.00
11.00 CAFETERIA	0	0	0	0	0	11.00
12.00 MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00 NURSING ADMINISTRATION	811,547	9,627	821,174	0	821,174	13.00
14.00 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00 PHARMACY	1,402,869	2,856,418	4,259,287	0	4,259,287	15.00
16.00 MEDICAL RECORDS & LIBRARY	116,879	151,441	268,320	0	268,320	16.00
17.00 SOCIAL SERVICE	121,102	729	121,831	0	121,831	17.00
17.01 PASTORAL CARE	89,707	383	90,090	0	90,090	17.01
18.00 OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0	18.00
19.00 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00 NURSING SCHOOL	0	0	0	0	0	20.00
21.00 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	7,915,134	3,802,389	11,717,523	0	11,717,523	30.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	145,333	303,388	448,721	0	448,721	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	194,783	167,222	362,005	0	362,005	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	120,201	1,382	121,583	0	121,583	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	779,804	779,804	0	779,804	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
61.00 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00 BLOOD STORING, PROCESSING & TRANS.	0	111,208	111,208	0	111,208	63.00
64.00 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 RESPIRATORY THERAPY	2,381,936	1,445,752	3,827,688	0	3,827,688	65.00
66.00 PHYSICAL THERAPY	492,027	106,623	598,650	0	598,650	66.00
67.00 OCCUPATIONAL THERAPY	310,625	30,215	340,840	0	340,840	67.00
68.00 SPEECH PATHOLOGY	147,005	2,276	149,281	0	149,281	68.00
69.00 ELECTROCARDIOLOGY	160,967	2,485	163,452	0	163,452	69.00
70.00 ELECTROENCEPHALOGRAPHY	1,957	561	2,518	0	2,518	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00 RENAL DIALYSIS	0	469,990	469,990	0	469,990	74.00
75.00 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1-117)	18,395,952	21,514,283	39,910,235	0	39,910,235	118.00
NONREIMBURSABLE COST CENTERS						
193.00 NONPAID WORKERS	0	0	0	0	0	193.00
193.01 MARKETING	0	0	0	0	0	193.01
200.00 TOTAL (SUM OF LINES 118-199)	18,395,952	21,514,283	39,910,235	0	39,910,235	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 152020

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

Worksheet A

Date/Time Prepared:
12/28/2011 4:43 pm

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
		6.00	7.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	436,126	1,548,539	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,440,240	2.00
3.00	OTHER CAP REL COSTS	0	0	3.00
4.00	EMPLOYEE BENEFITS	1,388,656	6,947,550	4.00
5.00	ADMINISTRATIVE & GENERAL	923,426	5,862,453	5.00
6.00	MAINTENANCE & REPAIRS	0	0	6.00
7.00	OPERATION OF PLANT	-2,141	1,021,993	7.00
8.00	LAUNDRY & LINEN SERVICE	0	0	8.00
9.00	HOUSEKEEPING	0	468,183	9.00
10.00	DIETARY	-142,296	571,083	10.00
11.00	CAFETERIA	0	0	11.00
12.00	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	NURSING ADMINISTRATION	0	821,174	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	14.00
15.00	PHARMACY	0	4,259,287	15.00
16.00	MEDICAL RECORDS & LIBRARY	-9,849	258,471	16.00
17.00	SOCIAL SERVICE	0	121,831	17.00
17.01	PASTORAL CARE	0	90,090	17.01
18.00	OTHER GENERAL SERVICE (SPECIFY)	0	0	18.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	19.00
20.00	NURSING SCHOOL	0	0	20.00
21.00	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	21.00
22.00	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	22.00
23.00	PARAMED ED PRGM-(SPECIFY)	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	1,487	11,719,010	30.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0	448,721	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	362,005	54.00
55.00	RADIOLOGY-THERAPEUTIC	0	0	55.00
56.00	RADIOISOTOPE	0	0	56.00
57.00	CT SCAN	0	121,583	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	59.00
60.00	LABORATORY	0	779,804	60.00
60.01	BLOOD LABORATORY	0	0	60.01
61.00	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0	111,208	63.00
64.00	INTRAVENOUS THERAPY	0	0	64.00
65.00	RESPIRATORY THERAPY	0	3,827,688	65.00
66.00	PHYSICAL THERAPY	0	598,650	66.00
67.00	OCCUPATIONAL THERAPY	0	340,840	67.00
68.00	SPEECH PATHOLOGY	0	149,281	68.00
69.00	ELECTROCARDIOLOGY	0	163,452	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	2,518	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	RENAL DIALYSIS	0	469,990	74.00
75.00	ASC (NON-DISTINCT PART)	0	0	75.00
SPECIAL PURPOSE COST CENTERS				
118.00	SUBTOTALS (SUM OF LINES 1-117)	2,595,409	42,505,644	118.00
NONREIMBURSABLE COST CENTERS				
193.00	NONPAID WORKERS	0	0	193.00
193.01	MARKETING	528,842	528,842	193.01
200.00	TOTAL (SUM OF LINES 118-199)	3,124,251	43,034,486	200.00

Provider CCN: 152020

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

Worksheet A-6

Date/Time Prepared:
12/28/2011 4:43 pm

Increases					
Cost Center	Line #	Salary	Other		
2.00	3.00	4.00	5.00		
A - INTEREST					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	4,506	1.00
	TOTALS		0	4,506	
500.00	Grand Total: Increases		0	4,506	500.00

Provider CCN: 152020

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

Worksheet A-6

Date/Time Prepared:
12/28/2011 4:43 pm

Decreases						
Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
6.00	7.00	8.00	9.00	10.00		
A - INTEREST						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	4,506	9	1.00
	TOTALS		0	4,506		
500.00	Grand Total: Decreases		0	4,506		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 152020

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
12/28/2011 4:43 pm

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	847,629	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	2.00
3.00	Buildings and Fixtures	20,934,136	229,492	0	229,492	3.00
4.00	Building Improvements	0	0	0	0	4.00
5.00	Fixed Equipment	0	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)	21,781,765	229,492	0	229,492	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	21,781,765	229,492	0	229,492	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	931,762	157,141	16,685	11,331	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	451,850	987,151	1,239	0	2.00
3.00	Total (sum of lines 1-2)	1,383,612	1,144,292	17,924	11,331	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	15,971,480	0	15,971,480	0.754666	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	5,192,148	0	5,192,148	0.245334	2.00
3.00	Total (sum of lines 1-2)	21,163,628	0	21,163,628	1.000000	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 152020

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
12/28/2011 4:43 pm

		Ending Balance	Fully Depreciated Assets			
		6.00	7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	847,629	0		1.00	
2.00	Land Improvements	0	0		2.00	
3.00	Buildings and Fixtures	21,163,628	0		3.00	
4.00	Building Improvements	0	0		4.00	
5.00	Fixed Equipment	0	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)	22,011,257	0		8.00	
9.00	Reconciling Items	0	0		9.00	
10.00	Total (line 8 minus line 9)	22,011,257	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	1,116,919		1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,440,240		2.00	
3.00	Total (sum of lines 1-2)	0	2,557,159		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	1,371,474	157,141
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	451,850	987,151
3.00	Total (sum of lines 1-2)	0	0	0	1,823,324	1,144,292

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 152020

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
12/28/2011 4:43 pm

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	8,593	11,331	0	0	1,548,539	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,239	0	0	0	1,440,240	2.00
3.00	Total (sum of lines 1-2)	9,832	11,331	0	0	2,988,779	3.00

		Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
		Basis/Code (2)	Amount	Cost Center	Line #
		1.00	2.00	3.00	4.00
1.00	Investment income - buildings and fixtures (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00 1.00
2.00	Investment income - movable equipment (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00 2.00
3.00	Investment income - other (chapter 2)		0		0.00 3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00 4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00 5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00 6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00 7.00
8.00	Television and radio service (chapter 21)		0		0.00 8.00
9.00	Parking lot (chapter 21)		0		0.00 9.00
10.00	Provider-based physician adjustment	A-8-2	0		0.00 10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00 11.00
12.00	Related organization transactions (chapter 10)	A-8-1	3,293,170		0.00 12.00
13.00	Laundry and linen service		0		0.00 13.00
14.00	Cafeteria-employees and guests	B	-142,296	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		0		0.00 18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00 19.00
20.00	Vending machines		0		0.00 20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00 21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00 22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00 23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00 24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00 25.00
26.00	Depreciation - buildings and fixtures		0	0CAP REL COSTS-BLDG & FIXT	1.00 26.00
27.00	Depreciation - movable equipment		0	0CAP REL COSTS-MVBLE EQUIP	2.00 27.00
28.00	Non-physician Anesthetist		0	0NONPHYSICIAN ANESTHETISTS	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	0OCCUPATIONAL THERAPY	67.00 30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	0SPEECH PATHOLOGY	68.00 31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00 32.00
33.00	MISCELLANEOUS INCOME	B	1,587	ADULTS & PEDIATRICS	30.00 33.00
33.01	MISCELLANEOUS INCOME	B	-2,414	ADMINISTRATIVE & GENERAL	5.00 33.01
33.02	MAINTENANCE INCOME	B	-2,141	OPERATION OF PLANT	7.00 33.02
33.03	MEDICAL RECORDS INCOME	B	-9,849	MEDICAL RECORDS & LIBRARY	16.00 33.03
33.04	CHARITY/DONATIONS	A	-10,936	ADMINISTRATIVE & GENERAL	5.00 33.04
33.05	CHARITY/DONATIONS	A	-100	ADULTS & PEDIATRICS	30.00 33.05
33.06	LOSS ON SALE OF FIXED ASSETS	A	-755	ADMINISTRATIVE & GENERAL	5.00 33.06
33.07	MARKETING	A	-26	ADMINISTRATIVE & GENERAL	5.00 33.07
33.08	NON-REIMBURSABLE ALCOHOL	A	-151	ADMINISTRATIVE & GENERAL	5.00 33.08
33.09	LOBBYING - NALTH	A	-643	ADMINISTRATIVE & GENERAL	5.00 33.09
33.10	LOBBYING - HOME OFFICE	A	-1,195	ADMINISTRATIVE & GENERAL	5.00 33.10
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		3,124,251		50.00

		Wkst. A-7 Ref.	
		5.00	
1.00	Investment income - buildings and fixtures (chapter 2)	0	1.00
2.00	Investment income - movable equipment (chapter 2)	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	MISCELLANEOUS INCOME	0	33.00
33.01	MISCELLANEOUS INCOME	0	33.01
33.02	MAINTENANCE INCOME	0	33.02
33.03	MEDICAL RECORDS INCOME	0	33.03
33.04	CHARITY/DONATIONS	0	33.04
33.05	CHARITY/DONATIONS	0	33.05
33.06	LOSS ON SALE OF FIXED ASSETS	0	33.06
33.07	MARKETING	0	33.07
33.08	NON-REIMBURSABLE ALCOHOL	0	33.08
33.09	LOBBYING - NALTH	0	33.09
33.10	LOBBYING - HOME OFFICE	0	33.10
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		50.00

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

Provider CCN: 152020

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

Worksheet A-8-1

Date/Time Prepared:
12/28/2011 4:43 pm

	Line No.	Cost Center	Expense Items	
	1.00	2.00	3.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	4.00	EMPLOYEE BENEFITS	EMPLOYEE BENEFITS CHARGEBACK	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	A&G CHARGEBACK	2.00
3.00	7.00	OPERATION OF PLANT	PLANT OPS CHARGEBACK	3.00
4.00	9.00	HOUSEKEEPING	HOUSEKEEPING CHARGEBACK	4.00
4.01	10.00	DIETARY	DIETARY CHARGEBACK	4.01
4.02	13.00	NURSING ADMINISTRATION	NURSING ADMIN CHARGEBACK	4.02
4.03	15.00	PHARMACY	PHARMACYCHARGEBACK	4.03
4.04	16.00	MEDICAL RECORDS & LIBRARY	MED RECS & LIB CHARGEBACK	4.04
4.05	17.01	PASTORAL CARE	PASTORAL CARE CHARGEBACK	4.05
4.06	30.00	ADULTS & PEDIATRICS	ADULTS & PEDS CHARGEBACK	4.06
4.07	50.00	OPERATING ROOM	OPERATING ROOM CHARGEBACK	4.07
4.08	54.00	RADIOLOGY-DIAGNOSTIC	RADIOLOGY CHARGEBACK	4.08
4.09	60.00	LABORATORY	LAB CHARGEBACK	4.09
4.10	65.00	RESPIRATORY THERAPY	RT CHARGEBACK	4.10
4.11	66.00	PHYSICAL THERAPY	PT CHARGEBACK	4.11
4.12	67.00	OCCUPATIONAL THERAPY	OT CHARGEBACK	4.12
4.13	68.00	SPEECH PATHOLOGY	ST CHARGEBACK	4.13
4.14	69.00	ELECTROCARDIOLOGY	EKG CHARGEBACK	4.14
4.15	70.00	ELECTROENCEPHALOGRAPHY	EEG CHARGEBACK	4.15
4.16	74.00	RENAL DIALYSIS	RENAL DIALYSIS CHARGEBACK	4.16
4.17	1.00	CAP REL COSTS-BLDG & FIXT	ST VINCENT HEALTH CAPITAL	4.17
4.18	5.00	ADMINISTRATIVE & GENERAL	ST VINCENT HEALTH A&G	4.18
4.19	193.01	MARKETING	ST VINCENT HEALTH MARKETING	4.19
4.20	4.00	EMPLOYEE BENEFITS	ASCENSION PLAN	4.20
4.21	1.00	CAP REL COSTS-BLDG & FIXT	ASCENSION INTEREST	4.21
4.22	5.00	ADMINISTRATIVE & GENERAL	ASCENSION INTEREST	4.22
4.23	4.00	EMPLOYEE BENEFITS	ST VINCENT HEALTH SELF INSURANCE	4.23
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 HEAL	100.00	6.00
7.00	G	ASCENSION	100.00	7.00
8.00			0.00	8.00
9.00			0.00	9.00
10.00			0.00	10.00
100.00	G. Other (financial or non-financial) specify:			100.00

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

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

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

Provider CCN: 152020

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

Worksheet A-8-1

Date/Time Prepared: 12/28/2011 4:43 pm

	Amount of Allowable Cost	Amount Included in wks. A, column 5	Net Adjustments (col. 4 minus col. 5)*	wkst. A-7 Ref.	
	4.00	5.00	6.00	7.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	370,998	370,998	0	0	1.00
2.00	257,498	257,498	0	0	2.00
3.00	2,304	2,304	0	0	3.00
4.00	62	62	0	0	4.00
4.01	353,279	353,279	0	0	4.01
4.02	84	84	0	0	4.02
4.03	28,750	28,750	0	0	4.03
4.04	157,105	157,105	0	0	4.04
4.05	89,707	89,707	0	0	4.05
4.06	155,205	155,205	0	0	4.06
4.07	214,043	214,043	0	0	4.07
4.08	340,438	340,438	0	0	4.08
4.09	4,781	4,781	0	0	4.09
4.10	5,524	5,524	0	0	4.10
4.11	995	995	0	0	4.11
4.12	192	192	0	0	4.12
4.13	381	381	0	0	4.13
4.14	2,377	2,377	0	0	4.14
4.15	561	561	0	0	4.15
4.16	-675	-675	0	0	4.16
4.17	444,218	0	444,218	9	4.17
4.18	3,287,532	2,344,992	942,540	0	4.18
4.19	528,842	0	528,842	0	4.19
4.20	981,828	981,828	0	0	4.20
4.21	4,087	12,179	-8,092	11	4.21
4.22	1,512	4,506	-2,994	0	4.22
4.23	3,086,266	1,697,610	1,388,656	0	4.23
5.00	10,317,894	7,024,724	3,293,170		5.00
TOTALS (sum of lines 1-4). Transfer column 6, line 5 to worksheet A-8, column 2, line 12.					

* 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	
	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 HEAL	100.00	HOME OFFICE	6.00
7.00	ASCENSION	100.00	HOME OFFICE	7.00
8.00		0.00		8.00
9.00		0.00		9.00
10.00		0.00		10.00
100.00	G. Other (financial or non-financial) specify:			100.00

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

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

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 152020

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

Worksheet B
Part I
Date/Time Prepared:
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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	1,548,539	1,548,539			1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,440,240		1,440,240		2.00
4.00	EMPLOYEE BENEFITS	6,947,550	0	0	6,947,550	4.00
5.00	ADMINISTRATIVE & GENERAL	5,862,453	47,316	44,007	1,064,371	7,018,147
6.00	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	OPERATION OF PLANT	1,021,993	119,571	111,209	145,824	1,398,597
8.00	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00	HOUSEKEEPING	468,183	32,220	29,967	84,072	614,442
10.00	DIETARY	571,083	66,935	62,253	134,980	835,251
11.00	CAFETERIA	0	0	0	0	11.00
12.00	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	NURSING ADMINISTRATION	821,174	108,931	101,313	310,736	1,342,154
14.00	CENTRAL SERVICES & SUPPLY	0	5,885	5,474	0	11,359
15.00	PHARMACY	4,259,287	39,303	36,554	537,150	4,872,294
16.00	MEDICAL RECORDS & LIBRARY	258,471	17,856	16,607	44,752	337,686
17.00	SOCIAL SERVICE	121,831	0	0	46,369	168,200
17.01	PASTORAL CARE	90,090	12,103	11,257	34,348	147,798
18.00	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	18.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	NURSING SCHOOL	0	0	0	0	20.00
21.00	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	21.00
22.00	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	22.00
23.00	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	11,719,010	1,014,160	943,234	3,030,668	16,707,072
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	448,721	5,952	5,536	55,647	515,856
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	362,005	21,281	19,792	74,581	477,659
55.00	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
56.00	RADIOISOTOPE	0	0	0	0	56.00
57.00	CT SCAN	121,583	5,653	5,257	46,024	178,517
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	779,804	4,622	4,299	0	788,725
60.01	BLOOD LABORATORY	0	0	0	0	60.01
61.00	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	111,208	0	0	0	111,208
64.00	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	3,827,688	11,571	10,762	912,029	4,762,050
66.00	PHYSICAL THERAPY	598,650	35,180	32,719	188,394	854,943
67.00	OCCUPATIONAL THERAPY	340,840	0	0	118,936	459,776
68.00	SPEECH PATHOLOGY	149,281	0	0	56,287	205,568
69.00	ELECTROCARDIOLOGY	163,452	0	0	61,633	225,085
70.00	ELECTROENCEPHALOGRAPHY	2,518	0	0	749	3,267
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	RENAL DIALYSIS	469,990	0	0	0	469,990
75.00	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	42,505,644	1,548,539	1,440,240	6,947,550	42,505,644
NONREIMBURSABLE COST CENTERS						
193.00	NONPAID WORKERS	0	0	0	0	0
193.01	MARKETING	528,842	0	0	0	528,842
200.00	Cross Foot Adjustments	0	0	0	0	0
201.00	Negative Cost Centers	0	0	0	0	0
202.00	TOTAL (sum lines 118-201)	43,034,486	1,548,539	1,440,240	6,947,550	43,034,486

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 152020

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

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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	7,018,147					5.00
6.00	MAINTENANCE & REPAIRS	0	0				6.00
7.00	OPERATION OF PLANT	272,531	0	1,671,128			7.00
8.00	LAUNDRY & LINEN SERVICE	0	0	0	0		8.00
9.00	HOUSEKEEPING	119,730	0	38,971	0	773,143	9.00
10.00	DIETARY	162,757	0	80,958	0	38,349	10.00
11.00	CAFETERIA	0	0	0	0	0	11.00
12.00	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	NURSING ADMINISTRATION	261,532	0	131,753	0	62,411	13.00
14.00	CENTRAL SERVICES & SUPPLY	2,213	0	7,119	0	3,372	14.00
15.00	PHARMACY	949,415	0	47,537	0	22,518	15.00
16.00	MEDICAL RECORDS & LIBRARY	65,801	0	21,597	0	10,230	16.00
17.00	SOCIAL SERVICE	32,775	0	0	0	0	17.00
17.01	PASTORAL CARE	28,800	0	14,639	0	6,935	17.01
18.00	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0	18.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	3,255,544	0	1,226,643	0	581,052	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	100,520	0	7,199	0	3,410	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	93,077	0	25,739	0	12,193	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	34,786	0	6,837	0	3,239	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	153,691	0	5,590	0	2,648	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
61.00	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	21,670	0	0	0	0	63.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	927,933	0	13,996	0	6,630	65.00
66.00	PHYSICAL THERAPY	166,594	0	42,550	0	20,156	66.00
67.00	OCCUPATIONAL THERAPY	89,592	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	40,057	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	43,860	0	0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	637	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	RENAL DIALYSIS	91,582	0	0	0	0	74.00
75.00	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	6,915,097	0	1,671,128	0	773,143	118.00
NONREIMBURSABLE COST CENTERS							
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	MARKETING	103,050	0	0	0	0	193.01
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	7,018,147	0	1,671,128	0	773,143	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 152020

Period:
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To 06/30/2011

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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	1,117,315					10.00
11.00	CAFETERIA	0	0				11.00
12.00	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	NURSING ADMINISTRATION	0	0	0	1,797,850		13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	0	0	24,063	14.00
15.00	PHARMACY	0	0	0	0	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	PASTORAL CARE	0	0	0	0	0	17.01
18.00	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0	18.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	1,117,315	0	0	1,321,983	0	30.00
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 SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	0	0	0	323,399	24,063	65.00
66.00	PHYSICAL THERAPY	0	0	0	85,160	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	46,248	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	21,060	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	1,117,315	0	0	1,797,850	24,063	118.00
NONREIMBURSABLE COST CENTERS							
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	MARKETING	0	0	0	0	0	193.01
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)	1,117,315	0	0	1,797,850	24,063	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 152020

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Cost Center Description		PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	PASTORAL CARE	
		15.00	16.00	17.00	17.01	
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	5,891,764				15.00
16.00	MEDICAL RECORDS & LIBRARY	0	435,314			16.00
17.00	SOCIAL SERVICE	0	0	200,975		17.00
17.01	PASTORAL CARE	0	0	0	198,172	17.01
18.00	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	18.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	NURSING SCHOOL	0	0	0	0	20.00
21.00	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	21.00
22.00	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	22.00
23.00	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	0	435,314	200,975	198,172	30.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	0	0	0	50.00
51.00	RECOVERY ROOM	0	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
55.00	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
56.00	RADIOISOTOPE	0	0	0	0	56.00
57.00	CT SCAN	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	LABORATORY	0	0	0	0	60.00
60.01	BLOOD LABORATORY	0	0	0	0	60.01
61.00	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	5,891,764	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
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	5,891,764	435,314	200,975	198,172	118.00
NONREIMBURSABLE COST CENTERS						
193.00	NONPAID WORKERS	0	0	0	0	193.00
193.01	MARKETING	0	0	0	0	193.01
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	5,891,764	435,314	200,975	198,172	202.00

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Cost Center Description	OTHER GENERAL SERVICE (SPECIFY)	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	INTERNS & RESIDENTS		
				SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS	
	18.00	19.00	20.00	21.00	22.00	
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						10.00
11.00						11.00
12.00						12.00
13.00						13.00
14.00						14.00
15.00						15.00
16.00						16.00
17.00						17.00
17.01						17.01
18.00	0					18.00
19.00	0	0				19.00
20.00	0	0	0			20.00
21.00	0	0	0	0		21.00
22.00	0	0	0	0	0	22.00
23.00	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	0	0	0	0	0	30.00
ANCILLARY SERVICE COST CENTERS						
50.00	0	0	0	0	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	0	0	0	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	0	0	0	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	0	0	0	0	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	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
SPECIAL PURPOSE COST CENTERS						
118.00	0	0	0	0	0	118.00
NONREIMBURSABLE COST CENTERS						
193.00	0	0	0	0	0	193.00
193.01	0	0	0	0	0	193.01
200.00	0	0	0	0	0	200.00
201.00	0	0	0	0	0	201.00
202.00	0	0	0	0	0	202.00

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COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 152020

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

Worksheet B
Part I
Date/Time Prepared:
12/28/2011 4:43 pm

Cost Center Description		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		23.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	EMPLOYEE BENEFITS					4.00
5.00	ADMINISTRATIVE & GENERAL					5.00
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
17.01	PASTORAL CARE					17.01
18.00	OTHER GENERAL SERVICE (SPECIFY)					18.00
19.00	NONPHYSICIAN ANESTHETISTS					19.00
20.00	NURSING SCHOOL					20.00
21.00	I&R SERVICES-SALARY & FRINGES APPRVD					21.00
22.00	I&R SERVICES-OTHER PRGM COSTS APPRVD					22.00
23.00	PARAMED ED PRGM-(SPECIFY)	0				23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	0	25,044,070	0	25,044,070	30.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	626,985	0	626,985	50.00
51.00	RECOVERY ROOM	0	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	608,668	0	608,668	54.00
55.00	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
56.00	RADIOISOTOPE	0	0	0	0	56.00
57.00	CT SCAN	0	223,379	0	223,379	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	LABORATORY	0	950,654	0	950,654	60.00
60.01	BLOOD LABORATORY	0	0	0	0	60.01
61.00	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0	132,878	0	132,878	63.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	0	6,058,071	0	6,058,071	65.00
66.00	PHYSICAL THERAPY	0	1,169,403	0	1,169,403	66.00
67.00	OCCUPATIONAL THERAPY	0	595,616	0	595,616	67.00
68.00	SPEECH PATHOLOGY	0	266,685	0	266,685	68.00
69.00	ELECTROCARDIOLOGY	0	268,945	0	268,945	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	3,904	0	3,904	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	5,891,764	0	5,891,764	73.00
74.00	RENAL DIALYSIS	0	561,572	0	561,572	74.00
75.00	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	42,402,594	0	42,402,594	118.00
NONREIMBURSABLE COST CENTERS						
193.00	NONPAID WORKERS	0	0	0	0	193.00
193.01	MARKETING	0	631,892	0	631,892	193.01
200.00	Cross Foot Adjustments	0	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	43,034,486	0	43,034,486	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 152020

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

Worksheet B
Part II
Date/Time Prepared:
12/28/2011 4:43 pm

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	
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	EMPLOYEE BENEFITS	0	0	0	0	4.00
5.00	ADMINISTRATIVE & GENERAL	0	47,316	44,007	91,323	5.00
6.00	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	OPERATION OF PLANT	0	119,571	111,209	230,780	7.00
8.00	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00	HOUSEKEEPING	0	32,220	29,967	62,187	9.00
10.00	DIETARY	0	66,935	62,253	129,188	10.00
11.00	CAFETERIA	0	0	0	0	11.00
12.00	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	NURSING ADMINISTRATION	0	108,931	101,313	210,244	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	5,885	5,474	11,359	14.00
15.00	PHARMACY	0	39,303	36,554	75,857	15.00
16.00	MEDICAL RECORDS & LIBRARY	0	17,856	16,607	34,463	16.00
17.00	SOCIAL SERVICE	0	0	0	0	17.00
17.01	PASTORAL CARE	0	12,103	11,257	23,360	17.01
18.00	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	18.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	NURSING SCHOOL	0	0	0	0	20.00
21.00	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	21.00
22.00	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	22.00
23.00	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	0	1,014,160	943,234	1,957,394	30.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	5,952	5,536	11,488	50.00
51.00	RECOVERY ROOM	0	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	21,281	19,792	41,073	54.00
55.00	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
56.00	RADIOISOTOPE	0	0	0	0	56.00
57.00	CT SCAN	0	5,653	5,257	10,910	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	LABORATORY	0	4,622	4,299	8,921	60.00
60.01	BLOOD LABORATORY	0	0	0	0	60.01
61.00	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	0	11,571	10,762	22,333	65.00
66.00	PHYSICAL THERAPY	0	35,180	32,719	67,899	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	RENAL DIALYSIS	0	0	0	0	74.00
75.00	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	1,548,539	1,440,240	2,988,779	118.00
NONREIMBURSABLE COST CENTERS						
193.00	NONPAID WORKERS	0	0	0	0	193.00
193.01	MARKETING	0	0	0	0	193.01
200.00	Cross Foot Adjustments	0	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	1,548,539	1,440,240	2,988,779	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 152020

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

Worksheet B
Part II
Date/Time Prepared:
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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	91,323					5.00
6.00	MAINTENANCE & REPAIRS	0	0				6.00
7.00	OPERATION OF PLANT	3,547	0	234,327			7.00
8.00	LAUNDRY & LINEN SERVICE	0	0	0	0		8.00
9.00	HOUSEKEEPING	1,558	0	5,465	0	69,210	9.00
10.00	DIETARY	2,118	0	11,352	0	3,433	10.00
11.00	CAFETERIA	0	0	0	0	0	11.00
12.00	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	NURSING ADMINISTRATION	3,404	0	18,475	0	5,587	13.00
14.00	CENTRAL SERVICES & SUPPLY	29	0	998	0	302	14.00
15.00	PHARMACY	12,356	0	6,666	0	2,016	15.00
16.00	MEDICAL RECORDS & LIBRARY	856	0	3,028	0	916	16.00
17.00	SOCIAL SERVICE	427	0	0	0	0	17.00
17.01	PASTORAL CARE	375	0	2,053	0	621	17.01
18.00	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0	18.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	42,355	0	172,000	0	52,015	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	1,308	0	1,009	0	305	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	1,211	0	3,609	0	1,091	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	453	0	959	0	290	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	2,000	0	784	0	237	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
61.00	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	282	0	0	0	0	63.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	12,077	0	1,963	0	593	65.00
66.00	PHYSICAL THERAPY	2,168	0	5,966	0	1,804	66.00
67.00	OCCUPATIONAL THERAPY	1,166	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	521	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	571	0	0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	8	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	RENAL DIALYSIS	1,192	0	0	0	0	74.00
75.00	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	89,982	0	234,327	0	69,210	118.00
NONREIMBURSABLE COST CENTERS							
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	MARKETING	1,341	0	0	0	0	193.01
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	91,323	0	234,327	0	69,210	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 152020

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

Worksheet B
Part II
Date/Time Prepared:
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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	146,091					10.00
11.00	CAFETERIA	0	0				11.00
12.00	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	NURSING ADMINISTRATION	0	0	0	237,710		13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	0	0	12,688	14.00
15.00	PHARMACY	0	0	0	0	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	PASTORAL CARE	0	0	0	0	0	17.01
18.00	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0	18.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	146,091	0	0	174,791	0	30.00
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 SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	0	0	0	42,759	12,688	65.00
66.00	PHYSICAL THERAPY	0	0	0	11,260	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	6,115	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	2,785	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	146,091	0	0	237,710	12,688	118.00
NONREIMBURSABLE COST CENTERS							
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	MARKETING	0	0	0	0	0	193.01
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)	146,091	0	0	237,710	12,688	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 152020

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

Worksheet B
Part II
Date/Time Prepared:
12/28/2011 4:43 pm

Cost Center Description		PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	PASTORAL CARE	
		15.00	16.00	17.00	17.01	
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	96,895				15.00
16.00	MEDICAL RECORDS & LIBRARY	0	39,263			16.00
17.00	SOCIAL SERVICE	0	0	427		17.00
17.01	PASTORAL CARE	0	0	0	26,409	17.01
18.00	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	18.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	NURSING SCHOOL	0	0	0	0	20.00
21.00	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	21.00
22.00	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	22.00
23.00	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	0	39,263	427	26,409	30.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	0	0	0	50.00
51.00	RECOVERY ROOM	0	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
55.00	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
56.00	RADIOISOTOPE	0	0	0	0	56.00
57.00	CT SCAN	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	LABORATORY	0	0	0	0	60.00
60.01	BLOOD LABORATORY	0	0	0	0	60.01
61.00	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	96,895	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
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	96,895	39,263	427	26,409	118.00
NONREIMBURSABLE COST CENTERS						
193.00	NONPAID WORKERS	0	0	0	0	193.00
193.01	MARKETING	0	0	0	0	193.01
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	96,895	39,263	427	26,409	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 152020

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

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description	OTHER GENERAL SERVICE (SPECIFY)	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	INTERNS & RESIDENTS		
	18.00	19.00	20.00	SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS	
				21.00	22.00	
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						10.00
11.00						11.00
12.00						12.00
13.00						13.00
14.00						14.00
15.00						15.00
16.00						16.00
17.00						17.00
17.01						17.01
18.00	0					18.00
19.00	0	0				19.00
20.00	0		0			20.00
21.00	0			0		21.00
22.00	0				0	22.00
23.00	0					23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	0					30.00
ANCILLARY SERVICE COST CENTERS						
50.00	0					50.00
51.00	0					51.00
52.00	0					52.00
53.00	0					53.00
54.00	0					54.00
55.00	0					55.00
56.00	0					56.00
57.00	0					57.00
58.00	0					58.00
59.00	0					59.00
60.00	0					60.00
60.01	0					60.01
61.00	0					61.00
62.00	0					62.00
63.00	0					63.00
64.00	0					64.00
65.00	0					65.00
66.00	0					66.00
67.00	0					67.00
68.00	0					68.00
69.00	0					69.00
70.00	0					70.00
71.00	0					71.00
72.00	0					72.00
73.00	0					73.00
74.00	0					74.00
75.00	0					75.00
SPECIAL PURPOSE COST CENTERS						
118.00	0	0	0	0	0	118.00
NONREIMBURSABLE COST CENTERS						
193.00	0					193.00
193.01	0					193.01
200.00		0	0	0	0	200.00
201.00	0	0	0	0	0	201.00
202.00	0	0	0	0	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 152020

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

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		23.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	EMPLOYEE BENEFITS					4.00
5.00	ADMINISTRATIVE & GENERAL					5.00
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
17.01	PASTORAL CARE					17.01
18.00	OTHER GENERAL SERVICE (SPECIFY)					18.00
19.00	NONPHYSICIAN ANESTHETISTS					19.00
20.00	NURSING SCHOOL					20.00
21.00	I&R SERVICES-SALARY & FRINGES APPRVD					21.00
22.00	I&R SERVICES-OTHER PRGM COSTS APPRVD					22.00
23.00	PARAMED ED PRGM-(SPECIFY)	0				23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS		2,610,745	0	2,610,745	30.00
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM		14,110	0	14,110	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		46,984	0	46,984	54.00
55.00	RADIOLOGY-THERAPEUTIC		0	0	0	55.00
56.00	RADIOISOTOPE		0	0	0	56.00
57.00	CT SCAN		12,612	0	12,612	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		11,942	0	11,942	60.00
60.01	BLOOD LABORATORY		0	0	0	60.01
61.00	PBP CLINICAL LAB SERVICES-PRGM ONLY		0	0	0	61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS		0	0	0	62.00
63.00	BLOOD STORING, PROCESSING & TRANS.		282	0	282	63.00
64.00	INTRAVENOUS THERAPY		0	0	0	64.00
65.00	RESPIRATORY THERAPY		92,413	0	92,413	65.00
66.00	PHYSICAL THERAPY		89,097	0	89,097	66.00
67.00	OCCUPATIONAL THERAPY		7,281	0	7,281	67.00
68.00	SPEECH PATHOLOGY		3,306	0	3,306	68.00
69.00	ELECTROCARDIOLOGY		571	0	571	69.00
70.00	ELECTROENCEPHALOGRAPHY		8	0	8	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS		96,895	0	96,895	73.00
74.00	RENAL DIALYSIS		1,192	0	1,192	74.00
75.00	ASC (NON-DISTINCT PART)		0	0	0	75.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	2,987,438	0	2,987,438	118.00
NONREIMBURSABLE COST CENTERS						
193.00	NONPAID WORKERS		0	0	0	193.00
193.01	MARKETING		1,341	0	1,341	193.01
200.00	Cross Foot Adjustments	0	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	2,988,779	0	2,988,779	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 152020

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	46,571				1.00
2.00	CAP REL COSTS-MVBLE EQUIP		46,571			2.00
4.00	EMPLOYEE BENEFITS	0	0	18,144,821		4.00
5.00	ADMINISTRATIVE & GENERAL	1,423	1,423	2,779,807	-7,018,147	36,016,339
6.00	MAINTENANCE & REPAIRS	0	0	0	0	0
7.00	OPERATION OF PLANT	3,596	3,596	380,848	0	1,398,597
8.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0
9.00	HOUSEKEEPING	969	969	219,569	0	614,442
10.00	DIETARY	2,013	2,013	352,525	0	835,251
11.00	CAFETERIA	0	0	0	0	0
12.00	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00	NURSING ADMINISTRATION	3,276	3,276	811,547	0	1,342,154
14.00	CENTRAL SERVICES & SUPPLY	177	177	0	0	11,359
15.00	PHARMACY	1,182	1,182	1,402,869	0	4,872,294
16.00	MEDICAL RECORDS & LIBRARY	537	537	116,879	0	337,686
17.00	SOCIAL SERVICE	0	0	121,102	0	168,200
17.01	PASTORAL CARE	364	364	89,707	0	147,798
18.00	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0
19.00	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
20.00	NURSING SCHOOL	0	0	0	0	0
21.00	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0
22.00	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0
23.00	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	30,500	30,500	7,915,134	0	16,707,072
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	179	179	145,333	0	515,856
51.00	RECOVERY ROOM	0	0	0	0	0
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0
53.00	ANESTHESIOLOGY	0	0	0	0	0
54.00	RADIOLOGY-DIAGNOSTIC	640	640	194,783	0	477,659
55.00	RADIOLOGY-THERAPEUTIC	0	0	0	0	0
56.00	RADIOISOTOPE	0	0	0	0	0
57.00	CT SCAN	170	170	120,201	0	178,517
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	LABORATORY	139	139	0	0	788,725
60.01	BLOOD LABORATORY	0	0	0	0	0
61.00	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	111,208
64.00	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	RESPIRATORY THERAPY	348	348	2,381,936	0	4,762,050
66.00	PHYSICAL THERAPY	1,058	1,058	492,027	0	854,943
67.00	OCCUPATIONAL THERAPY	0	0	310,625	0	459,776
68.00	SPEECH PATHOLOGY	0	0	147,005	0	205,568
69.00	ELECTROCARDIOLOGY	0	0	160,967	0	225,085
70.00	ELECTROENCEPHALOGRAPHY	0	0	1,957	0	3,267
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
74.00	RENAL DIALYSIS	0	0	0	0	469,990
75.00	ASC (NON-DISTINCT PART)	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	46,571	46,571	18,144,821	-7,018,147	35,487,497
NONREIMBURSABLE COST CENTERS						
193.00	NONPAID WORKERS	0	0	0	0	0
193.01	MARKETING	0	0	0	0	528,842
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per wkst. B, Part I)	1,548,539	1,440,240	6,947,550		7,018,147
203.00	Unit cost multiplier (wkst. B, Part I)	33.251143	30.925683	0.382894		0.194860
204.00	Cost to be allocated (per wkst. B, Part II)			0		91,323
205.00	Unit cost multiplier (wkst. B, Part II)			0.000000		0.002536

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 152020

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		MAINTENANCE & REPAIRS (SQARE FEET)	OPERATION OF PLANT (SQARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQARE FEET)	DIETARY (PATIENT DAYS)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
6.00	MAINTENANCE & REPAIRS	0					6.00
7.00	OPERATION OF PLANT	0	41,552				7.00
8.00	LAUNDRY & LINEN SERVICE	0	0	22,830			8.00
9.00	HOUSEKEEPING	0	969	0	40,583		9.00
10.00	DIETARY	0	2,013	0	2,013	22,830	10.00
11.00	CAFETERIA	0	0	0	0	0	11.00
12.00	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	NURSING ADMINISTRATION	0	3,276	0	3,276	0	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	177	0	177	0	14.00
15.00	PHARMACY	0	1,182	0	1,182	0	15.00
16.00	MEDICAL RECORDS & LIBRARY	0	537	0	537	0	16.00
17.00	SOCIAL SERVICE	0	0	0	0	0	17.00
17.01	PASTORAL CARE	0	364	0	364	0	17.01
18.00	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0	18.00
19.00	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	0	30,500	22,830	30,500	22,830	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	0	179	0	179	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	640	0	640	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	170	0	170	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	139	0	139	0	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	60.01
61.00	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	0	348	0	348	0	65.00
66.00	PHYSICAL THERAPY	0	1,058	0	1,058	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	41,552	22,830	40,583	22,830	118.00
NONREIMBURSABLE COST CENTERS							
193.00	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	MARKETING	0	0	0	0	0	193.01
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per wkst. B, Part I)	0	1,671,128	0	773,143	1,117,315	202.00
203.00	Unit cost multiplier (wkst. B, Part I)	0.000000	40.217751	0.000000	19.050908	48.940648	203.00
204.00	Cost to be allocated (per wkst. B, Part II)	0	234,327	0	69,210	146,091	204.00
205.00	Unit cost multiplier (wkst. B, Part II)	0.000000	5.639368	0.000000	1.705394	6.399080	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 152020

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

Worksheet B-1

Date/Time Prepared:
12/28/2011 4:43 pm

Cost Center Description	CAFETERIA (MEALS SERVED)	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						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						10.00
11.00	0					11.00
12.00	0	0				12.00
13.00	0	0	420,773			13.00
14.00	0	0	0	100		14.00
15.00	0	0	0	0	100	15.00
16.00	0	0	0	0	0	16.00
17.00	0	0	0	0	0	17.00
17.01	0	0	0	0	0	17.01
18.00	0	0	0	0	0	18.00
19.00	0	0	0	0	0	19.00
20.00	0	0	0	0	0	20.00
21.00	0	0	0	0	0	21.00
22.00	0	0	0	0	0	22.00
23.00	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	0	0	309,400	0	0	30.00
ANCILLARY SERVICE COST CENTERS						
50.00	0	0	0	0	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	0	0	0	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	0	0	0	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	75,689	100	0	65.00
66.00	0	0	19,931	0	0	66.00
67.00	0	0	10,824	0	0	67.00
68.00	0	0	4,929	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	0	71.00
72.00	0	0	0	0	0	72.00
73.00	0	0	0	0	100	73.00
74.00	0	0	0	0	0	74.00
75.00	0	0	0	0	0	75.00
SPECIAL PURPOSE COST CENTERS						
118.00	0	0	420,773	100	100	118.00
NONREIMBURSABLE COST CENTERS						
193.00	0	0	0	0	0	193.00
193.01	0	0	0	0	0	193.01
200.00						200.00
201.00						201.00
202.00	0	0	1,797,850	24,063	5,891,764	202.00
203.00	0.000000	0.000000	4.272731	240.630000	58,917.640000	203.00
204.00	0	0	237,710	12,688	96,895	204.00
205.00	0.000000	0.000000	0.564936	126.880000	968.950000	205.00

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Cost Center Description	MEDICAL RECORDS & LIBRARY (PATIENT DAYS)	SOCIAL SERVICE (PATIENT DAYS)	PASTORAL CARE (PATIENT DAYS)	OTHER GENERAL SERVICE (SPECIFY) (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
	16.00	17.00	17.01	18.00	19.00	
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						10.00
11.00						11.00
12.00						12.00
13.00						13.00
14.00						14.00
15.00						15.00
16.00	22,830					16.00
17.00	0	22,830				17.00
17.01	0	0	22,830			17.01
18.00	0	0	0	0		18.00
19.00	0	0	0	0	0	19.00
20.00	0	0	0	0	0	20.00
21.00	0	0	0	0	0	21.00
22.00	0	0	0	0	0	22.00
23.00	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	22,830	22,830	22,830	0		30.00
ANCILLARY SERVICE COST CENTERS						
50.00	0	0	0	0	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	0	0	0	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	0	0	0	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	0	0	0	0	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	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
SPECIAL PURPOSE COST CENTERS						
118.00	22,830	22,830	22,830	0	0	118.00
NONREIMBURSABLE COST CENTERS						
193.00	0	0	0	0	0	193.00
193.01	0	0	0	0	0	193.01
200.00						200.00
201.00						201.00
202.00	435,314	200,975	198,172	0	0	202.00
203.00	19.067630	8.803110	8.680333	0.000000	0.000000	203.00
204.00	39,263	427	26,409	0	0	204.00
205.00	1.719799	0.018703	1.156767	0.000000	0.000000	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 152020

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

Worksheet B-1

Date/Time Prepared:
12/28/2011 4:43 pm

Cost Center Description	INTERNS & RESIDENTS					
	NURSING SCHOOL (ASSIGNED TIME) 20.00	SERVICES-SALAR	SERVICES-OTHER	PARAMED ED		
		Y & FRINGES	PRGM COSTS	PRGM		
		(ASSIGNED TIME) 21.00	(ASSIGNED TIME) 22.00	(ASSIGNED TIME) 23.00		
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						10.00
11.00						11.00
12.00						12.00
13.00						13.00
14.00						14.00
15.00						15.00
16.00						16.00
17.00						17.00
17.01						17.01
18.00						18.00
19.00						19.00
20.00	0					20.00
21.00		0				21.00
22.00				0		22.00
23.00					0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	0	0	0	0	0	30.00
ANCILLARY SERVICE COST CENTERS						
50.00	0	0	0	0	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	0	0	0	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	0	0	0	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	0	0	0	0	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	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
SPECIAL PURPOSE COST CENTERS						
118.00	0	0	0	0	0	118.00
NONREIMBURSABLE COST CENTERS						
193.00	0	0	0	0	0	193.00
193.01	0	0	0	0	0	193.01
200.00						200.00
201.00						201.00
202.00	0	0	0	0	0	202.00
203.00	0.000000	0.000000	0.000000	0.000000	0.000000	203.00
204.00	0	0	0	0	0	204.00
205.00	0.000000	0.000000	0.000000	0.000000	0.000000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 152020

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

Worksheet C
Part I
Date/Time Prepared:
12/28/2011 4:43 pm

		Title XVIII		Hospital		PPS		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs					
			Total Costs	RCE Disallowance	Total Costs			
	1.00	2.00	3.00	4.00	5.00			
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS		25,044,070		25,044,070	0	25,044,070	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	OPERATING ROOM		626,985		626,985	0	626,985	50.00
51.00	RECOVERY ROOM		0		0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM		0		0	0	0	52.00
53.00	ANESTHESIOLOGY		0		0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC		608,668		608,668	0	608,668	54.00
55.00	RADIOLOGY-THERAPEUTIC		0		0	0	0	55.00
56.00	RADIOISOTOPE		0		0	0	0	56.00
57.00	CT SCAN		223,379		223,379	0	223,379	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		950,654		950,654	0	950,654	60.00
60.01	BLOOD LABORATORY		0		0	0	0	60.01
61.00	PBP CLINICAL LAB SERVICES-PRGM ONLY		0		0	0	0	61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS		0		0	0	0	62.00
63.00	BLOOD STORING, PROCESSING & TRANS.		132,878		132,878	0	132,878	63.00
64.00	INTRAVENOUS THERAPY		0		0	0	0	64.00
65.00	RESPIRATORY THERAPY		6,058,071	0	6,058,071	0	6,058,071	65.00
66.00	PHYSICAL THERAPY		1,169,403	0	1,169,403	0	1,169,403	66.00
67.00	OCCUPATIONAL THERAPY		595,616	0	595,616	0	595,616	67.00
68.00	SPEECH PATHOLOGY		266,685	0	266,685	0	266,685	68.00
69.00	ELECTROCARDIOLOGY		268,945	0	268,945	0	268,945	69.00
70.00	ELECTROENCEPHALOGRAPHY		3,904	0	3,904	0	3,904	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS		0		0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS		0		0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS		5,891,764	0	5,891,764	0	5,891,764	73.00
74.00	RENAL DIALYSIS		561,572		561,572	0	561,572	74.00
75.00	ASC (NON-DISTINCT PART)		0		0	0	0	75.00
200.00	Subtotal (see instructions)		42,402,594	0	42,402,594	0	42,402,594	200.00
201.00	Less Observation Beds		0		0	0	0	201.00
202.00	Total (see instructions)		42,402,594	0	42,402,594	0	42,402,594	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 152020	Period: From 07/01/2010 To 06/30/2011	Worksheet C Part I Date/Time Prepared: 12/28/2011 4:43 pm
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Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	PPS
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	37,502,620		37,502,620			30.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	2,635,106	0	2,635,106	0.237935	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	2,092,195	1,735	2,093,930	0.290682	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	1,321,475	5,121	1,326,596	0.168385	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	11,132,316	140	11,132,456	0.085395	0.000000	60.00
60.01 BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
61.00 PBP CLINICAL LAB SERVICES-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.	474,915	0	474,915	0.279793	0.000000	63.00
64.00 INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
65.00 RESPIRATORY THERAPY	22,468,985	43,407	22,512,392	0.269099	0.000000	65.00
66.00 PHYSICAL THERAPY	2,402,360	0	2,402,360	0.486773	0.000000	66.00
67.00 OCCUPATIONAL THERAPY	2,110,284	0	2,110,284	0.282244	0.000000	67.00
68.00 SPEECH PATHOLOGY	563,716	0	563,716	0.473084	0.000000	68.00
69.00 ELECTROCARDIOLOGY	360,773	946	361,719	0.743519	0.000000	69.00
70.00 ELECTROENCEPHALOGRAPHY	21,536	0	21,536	0.181278	0.000000	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00 DRUGS CHARGED TO PATIENTS	18,858,175	24	18,858,199	0.312425	0.000000	73.00
74.00 RENAL DIALYSIS	1,337,432	0	1,337,432	0.419888	0.000000	74.00
75.00 ASC (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	75.00
200.00 Subtotal (see instructions)	103,281,888	51,373	103,333,261			200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	103,281,888	51,373	103,333,261			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 152020	Period: From 07/01/2010 To 06/30/2011	Worksheet C Part I Date/Time Prepared: 12/28/2011 4:43 pm
	Title XVIII	Hospital	PPS

Cost Center Description	PPS Inpatient Ratio	
	11.00	
INPATIENT ROUTINE SERVICE COST CENTERS		
30.00 ADULTS & PEDIATRICS		30.00
ANCILLARY SERVICE COST CENTERS		
50.00 OPERATING ROOM	0.237935	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	0.290682	54.00
55.00 RADIOLOGY-THERAPEUTIC	0.000000	55.00
56.00 RADIOISOTOPE	0.000000	56.00
57.00 CT SCAN	0.168385	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	58.00
59.00 CARDIAC CATHETERIZATION	0.000000	59.00
60.00 LABORATORY	0.085395	60.00
60.01 BLOOD LABORATORY	0.000000	60.01
61.00 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	61.00
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	62.00
63.00 BLOOD STORING, PROCESSING & TRANS.	0.279793	63.00
64.00 INTRAVENOUS THERAPY	0.000000	64.00
65.00 RESPIRATORY THERAPY	0.269099	65.00
66.00 PHYSICAL THERAPY	0.486773	66.00
67.00 OCCUPATIONAL THERAPY	0.282244	67.00
68.00 SPEECH PATHOLOGY	0.473084	68.00
69.00 ELECTROCARDIOLOGY	0.743519	69.00
70.00 ELECTROENCEPHALOGRAPHY	0.181278	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00 DRUGS CHARGED TO PATIENTS	0.312425	73.00
74.00 RENAL DIALYSIS	0.419888	74.00
75.00 ASC (NON-DISTINCT PART)	0.000000	75.00
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: 152020

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

Worksheet C
Part I
Date/Time Prepared:
12/28/2011 4:43 pm

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		
	1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	25,044,070		25,044,070	0	0	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	626,985		626,985	0	0	50.00
51.00	RECOVERY ROOM	0		0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	608,668		608,668	0	0	54.00
55.00	RADIOLOGY-THERAPEUTIC	0		0	0	0	55.00
56.00	RADIOISOTOPE	0		0	0	0	56.00
57.00	CT SCAN	223,379		223,379	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	950,654		950,654	0	0	60.00
60.01	BLOOD LABORATORY	0		0	0	0	60.01
61.00	PBP CLINICAL LAB SERVICES-PRGM ONLY	0		0	0	0	61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0		0	0	0	62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	132,878		132,878	0	0	63.00
64.00	INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	RESPIRATORY THERAPY	6,058,071	0	6,058,071	0	0	65.00
66.00	PHYSICAL THERAPY	1,169,403	0	1,169,403	0	0	66.00
67.00	OCCUPATIONAL THERAPY	595,616	0	595,616	0	0	67.00
68.00	SPEECH PATHOLOGY	266,685	0	266,685	0	0	68.00
69.00	ELECTROCARDIOLOGY	268,945		268,945	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	3,904		3,904	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	5,891,764		5,891,764	0	0	73.00
74.00	RENAL DIALYSIS	561,572		561,572	0	0	74.00
75.00	ASC (NON-DISTINCT PART)	0		0	0	0	75.00
200.00	Subtotal (see instructions)	42,402,594	0	42,402,594	0	0	200.00
201.00	Less Observation Beds	0		0	0	0	201.00
202.00	Total (see instructions)	42,402,594	0	42,402,594	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 152020

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

Worksheet C
Part I
Date/Time Prepared:
12/28/2011 4:43 pm

Cost Center Description	Title XIX			Hospital	Cost	TEFRA Inpatient Ratio	
	Charges			Cost or Other Ratio			
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
6.00	7.00	8.00	9.00	10.00			
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	37,502,620		37,502,620			30.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	2,635,106	0	2,635,106	0.237935	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	2,092,195	1,735	2,093,930	0.290682	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	1,321,475	5,121	1,326,596	0.168385	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	11,132,316	140	11,132,456	0.085395	0.000000	60.00
60.01	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
61.00	PBP CLINICAL LAB SERVICES-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.	474,915	0	474,915	0.279793	0.000000	63.00
64.00	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
65.00	RESPIRATORY THERAPY	22,468,985	43,407	22,512,392	0.269099	0.000000	65.00
66.00	PHYSICAL THERAPY	2,402,360	0	2,402,360	0.486773	0.000000	66.00
67.00	OCCUPATIONAL THERAPY	2,110,284	0	2,110,284	0.282244	0.000000	67.00
68.00	SPEECH PATHOLOGY	563,716	0	563,716	0.473084	0.000000	68.00
69.00	ELECTROCARDIOLOGY	360,773	946	361,719	0.743519	0.000000	69.00
70.00	ELECTROENCEPHALOGRAPHY	21,536	0	21,536	0.181278	0.000000	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	DRUGS CHARGED TO PATIENTS	18,858,175	24	18,858,199	0.312425	0.000000	73.00
74.00	RENAL DIALYSIS	1,337,432	0	1,337,432	0.419888	0.000000	74.00
75.00	ASC (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	75.00
200.00	Subtotal (see instructions)	103,281,888	51,373	103,333,261			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	103,281,888	51,373	103,333,261			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 152020

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

Worksheet C
Part I
Date/Time Prepared:
12/28/2011 4:43 pm

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS				30.00
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 SERVICES-PRGM ONLY	0.000000			61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000			62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0.000000			63.00
64.00	INTRAVENOUS THERAPY	0.000000			64.00
65.00	RESPIRATORY THERAPY	0.000000			65.00
66.00	PHYSICAL THERAPY	0.000000			66.00
67.00	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	SPEECH PATHOLOGY	0.000000			68.00
69.00	ELECTROCARDIOLOGY	0.000000			69.00
70.00	ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	DRUGS CHARGED TO PATIENTS	0.000000			73.00
74.00	RENAL DIALYSIS	0.000000			74.00
75.00	ASC (NON-DISTINCT PART)	0.000000			75.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 152020		Period: From 07/01/2010 To 06/30/2011		Worksheet D Part I Date/Time Prepared: 12/28/2011 4:43 pm	
Title XVIII				Hospital		PPS	
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)		
	1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	2,610,745	0	2,610,745	22,830	114.36	30.00
200.00	Total (lines 30-199)	2,610,745		2,610,745	22,830		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 152020		Period: From 07/01/2010 To 06/30/2011		Worksheet D Part I Date/Time Prepared: 12/28/2011 4:43 pm	
		Title XVIII		Hospital		PPS	
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	15,081	1,724,663			30.00	
200.00	Total (lines 30-199)	15,081	1,724,663			200.00	

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 152020

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

Worksheet D
Part II
Date/Time Prepared:
12/28/2011 4:43 pm

Cost Center Description	Title XVIII			Hospital	PPS		
	Capital Related Cost (from wkst. B, Part II, col. 26)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
	1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	14,110	2,635,106	0.005355	1,851,170	9,913	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	46,984	2,093,930	0.022438	1,251,778	28,087	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	12,612	1,326,596	0.009507	744,485	7,078	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	11,942	11,132,456	0.001073	7,679,089	8,240	60.00
60.01	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
61.00	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0.000000	0	0	61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.000000	0	0	62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	282	474,915	0.000594	192,179	114	63.00
64.00	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	RESPIRATORY THERAPY	92,413	22,512,392	0.004105	15,332,694	62,941	65.00
66.00	PHYSICAL THERAPY	89,097	2,402,360	0.037087	1,520,265	56,382	66.00
67.00	OCCUPATIONAL THERAPY	7,281	2,110,284	0.003450	1,329,938	4,588	67.00
68.00	SPEECH PATHOLOGY	3,306	563,716	0.005865	362,799	2,128	68.00
69.00	ELECTROCARDIOLOGY	571	361,719	0.001579	220,375	348	69.00
70.00	ELECTROENCEPHALOGRAPHY	8	21,536	0.000371	7,610	3	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	96,895	18,858,199	0.005138	12,507,570	64,264	73.00
74.00	RENAL DIALYSIS	1,192	1,337,432	0.000891	1,061,496	946	74.00
75.00	ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
200.00	Total (lines 50-199)	376,693	65,830,641		44,061,448	245,032	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 152020

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

Worksheet D
Part IV
Date/Time Prepared:
12/28/2011 4:43 pm

Cost Center Description	Title XVIII				Hospital	PPS	Total Cost (sum of col 1 through col. 4)	
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost				
	1.00	2.00	3.00	4.00	5.00			
ANCILLARY SERVICE COST CENTERS								
50.00	OPERATING ROOM	0	0	0	0	0	0	50.00
51.00	RECOVERY ROOM	0	0	0	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.00
53.00	ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
55.00	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	0	55.00
56.00	RADIOISOTOPE	0	0	0	0	0	0	56.00
57.00	CT SCAN	0	0	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	0	59.00
60.00	LABORATORY	0	0	0	0	0	0	60.00
60.01	BLOOD LABORATORY	0	0	0	0	0	0	60.01
61.00	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	0	61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	0	62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	0	63.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
74.00	RENAL DIALYSIS	0	0	0	0	0	0	74.00
75.00	ASC (NON-DISTINCT PART)	0	0	0	0	0	0	75.00
200.00	Total (lines 50-199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 152020

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

Worksheet D
Part IV
Date/Time Prepared:
12/28/2011 4:43 pm

		Title XVIII			Hospital	PPS	
Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges		
	6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	0	2,635,106	0.000000	0.000000	1,851,170	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	2,093,930	0.000000	0.000000	1,251,778	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	1,326,596	0.000000	0.000000	744,485	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	LABORATORY	0	11,132,456	0.000000	0.000000	7,679,089	60.00
60.01	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
61.00	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0.000000	0.000000	0	61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.000000	0.000000	0	62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0	474,915	0.000000	0.000000	192,179	63.00
64.00	INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0	64.00
65.00	RESPIRATORY THERAPY	0	22,512,392	0.000000	0.000000	15,332,694	65.00
66.00	PHYSICAL THERAPY	0	2,402,360	0.000000	0.000000	1,520,265	66.00
67.00	OCCUPATIONAL THERAPY	0	2,110,284	0.000000	0.000000	1,329,938	67.00
68.00	SPEECH PATHOLOGY	0	563,716	0.000000	0.000000	362,799	68.00
69.00	ELECTROCARDIOLOGY	0	361,719	0.000000	0.000000	220,375	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	21,536	0.000000	0.000000	7,610	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	18,858,199	0.000000	0.000000	12,507,570	73.00
74.00	RENAL DIALYSIS	0	1,337,432	0.000000	0.000000	1,061,496	74.00
75.00	ASC (NON-DISTINCT PART)	0	0	0.000000	0.000000	0	75.00
200.00	Total (lines 50-199)	0	65,830,641			44,061,448	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 152020	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part IV Date/Time Prepared: 12/28/2011 4:43 pm
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Cost Center Description	Title XVIII			Hospital	PPS		
	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	0	50.00
51.00 RECOVERY ROOM	0	0	0	0	0	0	51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.00
53.00 ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	1,735	0	0	0	0	54.00
55.00 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	0	55.00
56.00 RADIOISOTOPE	0	0	0	0	0	0	56.00
57.00 CT SCAN	0	5,121	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	0	59.00
60.00 LABORATORY	0	140	0	0	0	0	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	0	60.01
61.00 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	0	61.00
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	0	62.00
63.00 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	0	63.00
64.00 INTRAVENOUS THERAPY	0	0	0	0	0	0	64.00
65.00 RESPIRATORY THERAPY	0	43,407	0	0	0	0	65.00
66.00 PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00 OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	0	946	0	0	0	0	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	24	0	0	0	0	73.00
74.00 RENAL DIALYSIS	0	0	0	0	0	0	74.00
75.00 ASC (NON-DISTINCT PART)	0	0	0	0	0	0	75.00
200.00 Total (lines 50-199)	0	51,373	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 152020	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part IV Date/Time Prepared: 12/28/2011 4:43 pm
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Cost Center Description	Title XVIII		Hospital	PPS
	PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost		
	23.00	24.00		
ANCILLARY SERVICE COST CENTERS				
50.00 OPERATING ROOM	0	0		50.00
51.00 RECOVERY ROOM	0	0		51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 ANESTHESIOLOGY	0	0		53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00 RADIOLOGY-THERAPEUTIC	0	0		55.00
56.00 RADIOISOTOPE	0	0		56.00
57.00 CT SCAN	0	0		57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00 CARDIAC CATHETERIZATION	0	0		59.00
60.00 LABORATORY	0	0		60.00
60.01 BLOOD LABORATORY	0	0		60.01
61.00 PBP CLINICAL LAB SERVICES-PRGM ONLY				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 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00 RENAL DIALYSIS	0	0		74.00
75.00 ASC (NON-DISTINCT PART)	0	0		75.00
200.00 Total (lines 50-199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 152020	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part V Date/Time Prepared: 12/28/2011 4:43 pm
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Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			PPS	
		PPS Reimbursed Services (see instructions)	Cost Reimbursed Services Subject To Ded. & Coins. (see instructions)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see instructions)		
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0.237935	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	0.290682	1,735	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	0.168385	5,121	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	0.085395	140	0	0	60.00
60.01	BLOOD LABORATORY	0.000000	0	0	0	60.01
61.00	PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	0	0	61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	0	62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0.279793	0	0	0	63.00
64.00	INTRAVENOUS THERAPY	0.000000	0	0	0	64.00
65.00	RESPIRATORY THERAPY	0.269099	43,407	0	0	65.00
66.00	PHYSICAL THERAPY	0.486773	0	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0.282244	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0.473084	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0.743519	946	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0.181278	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0.312425	24	0	0	73.00
74.00	RENAL DIALYSIS	0.419888	0	0	0	74.00
75.00	ASC (NON-DISTINCT PART)	0.000000	0	0	0	75.00
200.00	Subtotal (see instructions)		51,373	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)		51,373	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 152020	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part V Date/Time Prepared: 12/28/2011 4:43 pm
	Title XVIII	Hospital	PPS

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	504	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	862	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	12	0	0	60.00
60.01 BLOOD LABORATORY	0	0	0	60.01
61.00 PBP CLINICAL LAB SERVICES-PRGM ONLY		0	0	61.00
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	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	11,681	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	703	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 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00 DRUGS CHARGED TO PATIENTS	7	0	0	73.00
74.00 RENAL DIALYSIS	0	0	0	74.00
75.00 ASC (NON-DISTINCT PART)	0	0	0	75.00
200.00 Subtotal (see instructions)	13,769	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)	13,769	0	0	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 152020		Period: From 07/01/2010 To 06/30/2011		Worksheet D Part I Date/Time Prepared: 12/28/2011 4:43 pm		
			Title XIX		Hospital		Cost	
Cost Center Description		Capital Related Cost (from wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)		
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	2,610,745	0	2,610,745	22,830	114.36		30.00
200.00	Total (Lines 30-199)	2,610,745		2,610,745	22,830			200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 152020		Period: From 07/01/2010 To 06/30/2011		Worksheet D Part I Date/Time Prepared: 12/28/2011 4:43 pm	
		Title XIX		Hospital		Cost	
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	882	100,866			30.00	
200.00	Total (lines 30-199)	882	100,866			200.00	

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 152020	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part II Date/Time Prepared: 12/28/2011 4:43 pm
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Cost Center Description	Title XIX			Hospital	Cost		
	Capital Related Cost (from wkst. B, Part II, col. 26)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
	1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	14,110	2,635,106	0.005355	66,288	355	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	46,984	2,093,930	0.022438	131,458	2,950	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	12,612	1,326,596	0.009507	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	11,942	11,132,456	0.001073	401,288	431	60.00
60.01	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
61.00	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0.000000	0	0	61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.000000	0	0	62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	282	474,915	0.000594	0	0	63.00
64.00	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	RESPIRATORY THERAPY	92,413	22,512,392	0.004105	893,960	3,670	65.00
66.00	PHYSICAL THERAPY	89,097	2,402,360	0.037087	82,686	3,067	66.00
67.00	OCCUPATIONAL THERAPY	7,281	2,110,284	0.003450	85,062	293	67.00
68.00	SPEECH PATHOLOGY	3,306	563,716	0.005865	17,139	101	68.00
69.00	ELECTROCARDIOLOGY	571	361,719	0.001579	11,302	18	69.00
70.00	ELECTROENCEPHALOGRAPHY	8	21,536	0.000371	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	96,895	18,858,199	0.005138	825,832	4,243	73.00
74.00	RENAL DIALYSIS	1,192	1,337,432	0.000891	56,356	50	74.00
75.00	ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
200.00	Total (lines 50-199)	376,693	65,830,641		2,571,371	15,178	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 152020		Period: From 07/01/2010 To 06/30/2011		Worksheet D Part III Date/Time Prepared: 12/28/2011 4:43 pm	
Cost Center Description	Title XIX			Hospital		Total Costs (sum of cols. 1 through 3, minus col. 4)	
	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Cost		
	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
200.00	Total (lines 30-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 152020		Period: From 07/01/2010 To 06/30/2011		Worksheet D Part III Date/Time Prepared: 12/28/2011 4:43 pm		
			Title XIX		Hospital		Cost	
Cost Center Description		Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. Nursing School		
		6.00	7.00	8.00	9.00	11.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	22,830	0.00	882	0	0		30.00
200.00	Total (lines 30-199)	22,830		882	0	0		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 152020		Period: From 07/01/2010 To 06/30/2011	Worksheet D Part III Date/Time Prepared: 12/28/2011 4:43 pm
			Title XIX	Hospital	Cost
Cost Center Description		PSA Adj. Allied Health Cost	PSA Adj. All. Other Medical Education Cost		
		12.00	13.00		
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS	0	0	30.00	
200.00	Total (lines 30-199)	0	0	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 152020

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

Worksheet D
Part IV
Date/Time Prepared:
12/28/2011 4:43 pm

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 SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
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: 152020

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

Worksheet D
Part IV
Date/Time Prepared:
12/28/2011 4:43 pm

Cost Center Description	Title XIX			Hospital		Inpatient Program Charges	Cost
	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)			
	6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS							
50.00 OPERATING ROOM	0	2,635,106	0.000000	0.000000		66,288	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	2,093,930	0.000000	0.000000		131,458	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	1,326,596	0.000000	0.000000		0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000		0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0.000000	0.000000		0	59.00
60.00 LABORATORY	0	11,132,456	0.000000	0.000000		401,288	60.00
60.01 BLOOD LABORATORY	0	0	0.000000	0.000000		0	60.01
61.00 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0.000000	0.000000		0	61.00
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.000000	0.000000		0	62.00
63.00 BLOOD STORING, PROCESSING & TRANS.	0	474,915	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	22,512,392	0.000000	0.000000		893,960	65.00
66.00 PHYSICAL THERAPY	0	2,402,360	0.000000	0.000000		82,686	66.00
67.00 OCCUPATIONAL THERAPY	0	2,110,284	0.000000	0.000000		85,062	67.00
68.00 SPEECH PATHOLOGY	0	563,716	0.000000	0.000000		17,139	68.00
69.00 ELECTROCARDIOLOGY	0	361,719	0.000000	0.000000		11,302	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	21,536	0.000000	0.000000		0	70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0.000000		0	71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0.000000		0	72.00
73.00 DRUGS CHARGED TO PATIENTS	0	18,858,199	0.000000	0.000000		825,832	73.00
74.00 RENAL DIALYSIS	0	1,337,432	0.000000	0.000000		56,356	74.00
75.00 ASC (NON-DISTINCT PART)	0	0	0.000000	0.000000		0	75.00
200.00 Total (lines 50-199)	0	65,830,641				2,571,371	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 152020

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

Worksheet D
Part IV
Date/Time Prepared:
12/28/2011 4:43 pm

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 SERVICES-PRGM ONLY						61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
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: 152020

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

Worksheet D
Part IV
Date/Time Prepared:
12/28/2011 4:43 pm

Cost Center Description	Title XIX		Hospital	Cost
	PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost		
	23.00	24.00		
ANCILLARY SERVICE COST CENTERS				
50.00 OPERATING ROOM	0	0		50.00
51.00 RECOVERY ROOM	0	0		51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 ANESTHESIOLOGY	0	0		53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00 RADIOLOGY-THERAPEUTIC	0	0		55.00
56.00 RADIOISOTOPE	0	0		56.00
57.00 CT SCAN	0	0		57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00 CARDIAC CATHETERIZATION	0	0		59.00
60.00 LABORATORY	0	0		60.00
60.01 BLOOD LABORATORY	0	0		60.01
61.00 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0		61.00
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62.00
63.00 BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
64.00 INTRAVENOUS THERAPY	0	0		64.00
65.00 RESPIRATORY THERAPY	0	0		65.00
66.00 PHYSICAL THERAPY	0	0		66.00
67.00 OCCUPATIONAL THERAPY	0	0		67.00
68.00 SPEECH PATHOLOGY	0	0		68.00
69.00 ELECTROCARDIOLOGY	0	0		69.00
70.00 ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00 RENAL DIALYSIS	0	0		74.00
75.00 ASC (NON-DISTINCT PART)	0	0		75.00
200.00 Total (lines 50-199)	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 152020	Period: From 07/01/2010 To 06/30/2011	Worksheet D-1 Date/Time Prepared: 12/28/2011 4:43 pm
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Cost Center Description		Title XVIII	Hospital	PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			22,830 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			22,830 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)			22,830 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			0 5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			0 7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			15,081 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)			25,044,070 21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)			0 22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)			0 23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			0 24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)			0 25.00
26.00	Total swing-bed cost (see instructions)			0 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			25,044,070 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)			37,502,620 28.00
29.00	Private room charges (excluding swing-bed charges)			37,502,620 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.667795 31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00 32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00 34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00 35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0 36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			25,044,070 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)			1,096.98 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			16,543,555 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)			16,543,555 41.00

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COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 152020	Period: From 07/01/2010 To 06/30/2011	Worksheet D-1 Date/Time Prepared: 12/28/2011 4:43 pm
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Cost Center Description	Title XVIII			Hospital	PPS	
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
42.00 NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00	42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT						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)					11,570,871	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					28,114,426	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)					1,724,663	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from wkst. D, sum of Parts II and IV)					245,032	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					1,969,695	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					26,144,731	53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00 Program discharges					0	54.00
55.00 Target amount per discharge					0.00	55.00
56.00 Target amount (line 54 x line 55)					0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00 Bonus payment (see instructions)					0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00 Relief payment (see instructions)					0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY						
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)						70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00 Program routine service cost (line 9 x line 71)						72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from worksheet B, Part II, column 26, line 45)						75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00 Program capital-related costs (line 9 x line 76)						77.00
78.00 Inpatient routine service cost (line 74 minus line 77)						78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00 Inpatient routine service cost per diem limitation						81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00 Reasonable inpatient routine service costs (see instructions)						83.00
84.00 Program inpatient ancillary services (see instructions)						84.00
85.00 Utilization review - physician compensation (see instructions)						85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00 Total observation bed days (see instructions)					0	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

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COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 152020		Period: From 07/01/2010 To 06/30/2011		Worksheet D-1 Date/Time Prepared: 12/28/2011 4:43 pm	
Cost Center Description		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	2,610,745	25,044,070	0.104246	0	0	90.00
91.00	Nursing School cost	0	25,044,070	0.000000	0	0	91.00
92.00	Allied health cost	0	25,044,070	0.000000	0	0	92.00
93.00	All other Medical Education	0	25,044,070	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 152020	Period: From 07/01/2010 To 06/30/2011	Worksheet D-1 Date/Time Prepared: 12/28/2011 4:43 pm
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Title XIX		Hospital	Cost	
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		22,830	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		22,830	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)		22,830	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		882	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)		25,044,070	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		25,044,070	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		37,502,620	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.667795	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		25,044,070	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)		1,096.98	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		967,536	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)		967,536	41.00

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COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 152020

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

Worksheet D-1

Date/Time Prepared:
12/28/2011 4:43 pm

		Title XIX			Hospital	Cost	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	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					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)					691,258	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,658,794	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 152020

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

Worksheet D-1

Date/Time Prepared:
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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	90.00
91.00	Nursing School cost	0	0	0.000000	0	91.00
92.00	Allied health cost	0	0	0.000000	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 152020	Period: From 07/01/2010 To 06/30/2011	Worksheet D-3 Date/Time Prepared: 12/28/2011 4:43 pm
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Cost Center Description	Title XVIII		Hospital		PPS	
	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		24,038,351				30.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0.237935	1,851,170	440,458			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	0.290682	1,251,778	363,869			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	0.168385	744,485	125,360			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	0.085395	7,679,089	655,756			60.00
60.01 BLOOD LABORATORY	0.000000	0	0			60.01
61.00 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	0			61.00
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0			62.00
63.00 BLOOD STORING, PROCESSING & TRANS.	0.279793	192,179	53,770			63.00
64.00 INTRAVENOUS THERAPY	0.000000	0	0			64.00
65.00 RESPIRATORY THERAPY	0.269099	15,332,694	4,126,013			65.00
66.00 PHYSICAL THERAPY	0.486773	1,520,265	740,024			66.00
67.00 OCCUPATIONAL THERAPY	0.282244	1,329,938	375,367			67.00
68.00 SPEECH PATHOLOGY	0.473084	362,799	171,634			68.00
69.00 ELECTROCARDIOLOGY	0.743519	220,375	163,853			69.00
70.00 ELECTROENCEPHALOGRAPHY	0.181278	7,610	1,380			70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0			71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0			72.00
73.00 DRUGS CHARGED TO PATIENTS	0.312425	12,507,570	3,907,678			73.00
74.00 RENAL DIALYSIS	0.419888	1,061,496	445,709			74.00
75.00 ASC (NON-DISTINCT PART)	0.000000	0	0			75.00
200.00 Total (sum of lines 50-94 and 96-98)		44,061,448	11,570,871			200.00
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0			201.00
202.00 Net charges (line 200 minus line 201)		44,061,448				202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 152020	Period: From 07/01/2010 To 06/30/2011	Worksheet D-3 Date/Time Prepared: 12/28/2011 4:43 pm
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Cost Center Description	Title XIX		Hospital		Cost
	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)		
	1.00	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 ADULTS & PEDIATRICS		1,429,978			30.00
ANCILLARY SERVICE COST CENTERS					
50.00 OPERATING ROOM	0.237935	66,288	15,772		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	0.290682	131,458	38,212		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	0.168385	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	0.085395	401,288	34,268		60.00
60.01 BLOOD LABORATORY	0.000000	0	0		60.01
61.00 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	0		61.00
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0		62.00
63.00 BLOOD STORING, PROCESSING & TRANS.	0.279793	0	0		63.00
64.00 INTRAVENOUS THERAPY	0.000000	0	0		64.00
65.00 RESPIRATORY THERAPY	0.269099	893,960	240,564		65.00
66.00 PHYSICAL THERAPY	0.486773	82,686	40,249		66.00
67.00 OCCUPATIONAL THERAPY	0.282244	85,062	24,008		67.00
68.00 SPEECH PATHOLOGY	0.473084	17,139	8,108		68.00
69.00 ELECTROCARDIOLOGY	0.743519	11,302	8,403		69.00
70.00 ELECTROENCEPHALOGRAPHY	0.181278	0	0		70.00
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0		71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0		72.00
73.00 DRUGS CHARGED TO PATIENTS	0.312425	825,832	258,011		73.00
74.00 RENAL DIALYSIS	0.419888	56,356	23,663		74.00
75.00 ASC (NON-DISTINCT PART)	0.000000	0	0		75.00
200.00 Total (sum of lines 50-94 and 96-98)		2,571,371	691,258		200.00
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0		201.00
202.00 Net charges (line 200 minus line 201)		2,571,371			202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 152020	Period: From 07/01/2010 To 06/30/2011	Worksheet E Part B Date/Time Prepared: 12/28/2011 4:43 pm
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPI (see instructions)		13,769	2.00
3.00	PPS payments		1,158	3.00
4.00	Outlier payment (see instructions)		1,750	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from worksheet D, Part IV, column 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from worksheet D-4, Part III, line 69, col. 4)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)		0	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		2,908	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		260	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)		2,648	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)		2,648	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		2,648	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)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)		2,648	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)		2,648	40.00
41.00	Interim payments		2,648	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)		0	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: 152020	Period: From 07/01/2010 To 06/30/2011	Worksheet E Part B Date/Time Prepared: 12/28/2011 4:43 pm
Title XVIII		Hospital	PPS
			Overrides
			1.00
WORKSHEET OVERRIDE VALUES			

112.00 Override of Ancillary service charges (line 12)	0 112.00
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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 152020		Period: From 07/01/2010 To 06/30/2011		Worksheet E-1 Part I Date/Time Prepared: 12/28/2011 4:43 pm	
		Title XVIII		Hospital		PPS	
		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		24,803,530		2,648	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		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)		24,803,530		2,648	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		457,469		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		25,260,999		2,648	7.00	
				Contractor Number	Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor						8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 152020	Period: From 07/01/2010 To 06/30/2011	Worksheet E-3 Part IV Date/Time Prepared: 12/28/2011 4:43 pm
		Title XVIII	Hospital	PPS
				1.00
PART IV - MEDICARE PART A SERVICES - LTCH PPS				
1.00	Net Federal PPS Payments (see instructions)			22,614,169 1.00
2.00	Outlier Payments			3,874,142 2.00
3.00	Total PPS Payments (sum of lines 1 and 2)			26,488,311 3.00
4.00	Nursing and Allied Health Managed Care payments (see instructions)			0 4.00
5.00	Organ acquisition			0 5.00
6.00	Cost of teaching physicians			0 6.00
7.00	Subtotal (see instructions)			26,488,311 7.00
8.00	Primary payer payments			125,169 8.00
9.00	Subtotal (line 7 less line 8).			26,363,142 9.00
10.00	Deductibles			39,952 10.00
11.00	Subtotal (line 9 minus line 10)			26,323,190 11.00
12.00	Coinsurance			1,519,660 12.00
13.00	Subtotal (line 11 minus line 12)			24,803,530 13.00
14.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			653,527 14.00
15.00	Adjusted reimbursable bad debts (see instructions)			457,469 15.00
16.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			601,924 16.00
17.00	Subtotal (sum of lines 13 and 15)			25,260,999 17.00
18.00	Direct graduate medical education payments (from worksheet E-4, line 49)			0 18.00
19.00	Other pass through costs (see instructions)			0 19.00
20.00	Outlier payments reconciliation			0 20.00
21.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 21.00
21.99	Recovery of Accelerated Depreciation			0 21.99
22.00	Total amount payable to the provider (see instructions)			25,260,999 22.00
23.00	Interim payments			24,803,530 23.00
24.00	Tentative settlement (for contractor use only)			0 24.00
25.00	Balance due provider/program (line 22 minus the sum lines 23 and 24)			457,469 25.00
26.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2			0 26.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from worksheet E-3, Part IV, line 2			0 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 152020	Period: From 07/01/2010 To 06/30/2011	Worksheet E-3 Part VII Date/Time Prepared: 12/28/2011 4:43 pm
		Title XIX	Hospital	Cost
				1.00
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		1,658,794	1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)		0	3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		1,658,794	4.00
5.00	Inpatient primary payer payments		0	5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		1,658,794	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges		1,429,978	8.00
9.00	Ancillary service charges		2,571,371	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)		4,001,349	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)		4,001,349	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 7) (see instructions)		2,342,555	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 7 exceeds line 16) (see instructions)		0	18.00
19.00	Interns and Residents (see instructions)		0	19.00
20.00	Cost of Teaching Physicians (see instructions)		0	20.00
21.00	Cost of covered services (line 7)		1,658,794	21.00
PROSPECTIVE PAYMENT AMOUNT				
22.00	Other than outlier payments		0	22.00
23.00	Outlier payments		0	23.00
24.00	Program capital payments		0	24.00
25.00	Capital exception payments (see instructions)		0	25.00
26.00	Routine and Ancillary service other pass through costs		0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	27.00
28.00	Customary charges (title XIX PPS covered services only)		0	28.00
29.00	Titles V or XIX PPS, lessor of lines 27 or 28; non-PPS enter amount from line 27		0	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 through 21, plus line 29, minus line 30)		1,658,794	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)		1,658,794	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	37.00
38.00	Subtotal (line 36 ± line 37)		1,658,794	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)		1,658,794	40.00
41.00	Interim payments		1,658,794	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

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

Provider CCN: 152020

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

Worksheet G

Date/Time Prepared:
12/28/2011 4:43 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	2,357,943	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	6,064,132	0	0	0	4.00
5.00	Other receivable	4,897	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-133,702	0	0	0	6.00
7.00	Inventory	330,810	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	449,960	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	9,074,040	0	0	0	11.00
FIXED ASSETS						
12.00	Land	847,629	0	0	0	12.00
13.00	Land improvements	3,157	0	0	0	13.00
14.00	Accumulated depreciation	-973	0	0	0	14.00
15.00	Buildings	15,968,323	0	0	0	15.00
16.00	Accumulated depreciation	-3,463,795	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	5,192,148	0	0	0	23.00
24.00	Accumulated depreciation	-3,152,547	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)	15,393,942	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	43,996,617	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	13,508	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	44,010,125	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	68,478,107	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,008,958	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,589,113	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	2,419,219	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	6,017,290	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	432,077	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	432,077	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	6,449,367	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	62,028,740				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	62,028,740	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	68,478,107	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 152020

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

Worksheet G-1

Date/Time Prepared:
12/28/2011 4:43 pm

	General Fund		Special Purpose Fund		
	1.00	2.00	3.00	4.00	
	1.00		49,693,693		
2.00		11,811,954			2.00
3.00		61,505,647		0	3.00
4.00	523,093				4.00
5.00	0			0	5.00
6.00	0			0	6.00
7.00	0			0	7.00
8.00	0			0	8.00
9.00	0			0	9.00
10.00		523,093		0	10.00
11.00		62,028,740		0	11.00
12.00	0			0	12.00
13.00	0			0	13.00
14.00	0			0	14.00
15.00	0			0	15.00
16.00	0			0	16.00
17.00	0			0	17.00
18.00		0		0	18.00
19.00		62,028,740		0	19.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 152020

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

Worksheet G-1

Date/Time Prepared:
12/28/2011 4:43 pm

	Endowment Fund		Plant Fund			
	5.00	6.00	7.00	8.00		
1.00			0		0	1.00
2.00						2.00
3.00			0		0	3.00
4.00	0			0		4.00
5.00	0			0		5.00
6.00	0			0		6.00
7.00	0			0		7.00
8.00	0			0		8.00
9.00	0			0		9.00
10.00			0		0	10.00
11.00			0		0	11.00
12.00	0			0		12.00
13.00	0			0		13.00
14.00	0			0		14.00
15.00	0			0		15.00
16.00	0			0		16.00
17.00	0			0		17.00
18.00			0		0	18.00
19.00			0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 152020

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

Worksheet G-2 Parts

Date/Time Prepared:
12/28/2011 4:43 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	37,502,620		37,502,620	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	37,502,620		37,502,620	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	37,502,620		37,502,620	17.00
18.00	Ancillary services	65,830,641	0	65,830,641	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to wkst. G-3, line 1)	103,333,261	0	103,333,261	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per wkst. A, column 3, line 200)		39,910,235		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)		39,910,235		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 152020	Period: From 07/01/2010 To 06/30/2011	Worksheet G-3 Date/Time Prepared: 12/28/2011 4:43 pm
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		1.00	
1.00	Total patient revenues (from wkst. G-2, Part I, column 3, line 28)	103,333,261	1.00
2.00	Less contractual allowances and discounts on patients' accounts	57,974,884	2.00
3.00	Net patient revenues (line 1 minus line 2)	45,358,377	3.00
4.00	Less total operating expenses (from wkst. G-2, Part II, line 43)	39,910,235	4.00
5.00	Net income from service to patients (line 3 minus line 4)	5,448,142	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	5,947,611	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	142,296	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	9,849	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	1,484	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER - NURSING, MAINT, A&G, GRANTS	24,624	24.00
25.00	Total other income (sum of lines 6-24)	6,125,864	25.00
26.00	Total (line 5 plus line 25)	11,574,006	26.00
27.00	BAD DEBT	-237,948	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	-237,948	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	11,811,954	29.00