

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

**MEDICARE PROVIDER NO. 15-2021
AND MEDICAID AIM NO. 200413490A**

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

JUNE 30, 2011

ST. VINCENT SETON SPECIALTY HOSPITAL
LAFAYETTE, IN

MEDICARE PROVIDER NO. 15-2021
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Accountants' Disclaimer

Hospital Statements of Reimbursable Costs



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

We have compiled the Hospital Statements of Reimbursable Costs (Title XVIII and XIX) of St. Vincent Seton Specialty Hospital-Lafayette 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 29, 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: 152021	Period: From 07/01/2010 To 06/30/2011	Worksheet 5 Parts I-III Date/Time Prepared: 12/29/2011 10:47 am
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PART I - COST REPORT STATUS

Provider use only

1. Electronically filed cost report Date: 12/29/2011 Time: 10:47 am

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.

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-LAF 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: 10:47 am
 f:YKQtcs3ZgevyzwhGkvsuvau0Iz0
 eNAX50dx88nLaeZG25alzh04VqCTAW
 kTCp0e72K20j3kRg
 PI: Date: 12/29/2011 Time: 10:47 am
 PwqyW17DKBj4CRtT4bCPFD.RMildn0
 NINuY005L848x9L3MEYlJEqRRu8MLQ
 :ipAIPuiQP0.Kfck

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

 Title

 Date

	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	140,792	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	140,792	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: 152021		Period: From 07/01/2010 To 06/30/2011		Worksheet S-2 Part I Date/Time Prepared: 12/29/2011 10:42 am		
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 1501 HARTFORD STREET			PO Box:						
2.00	City: LAFAYETTE			State: IN		Zip Code: 47904		County: TIPPECANOE		
				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-LAF	152021	29140	2	02/07/2003	N P O	
4.00	Subprovider - IPF									
5.00	Subprovider - IRF									
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF							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: 152021	Period: From 07/01/2010 To 06/30/2011	Worksheet S-2 Part I Date/Time Prepared: 12/29/2011 10:42 am
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		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)		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: 152021	Period: From 07/01/2010 To 06/30/2011	Worksheet S-2 Part I Date/Time Prepared: 12/29/2011 10:42 am		
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))		
		1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010						
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000		66.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))
		1.00	2.00	3.00	4.00	5.00
67.00	Enter in column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	0.00	0.00	0.000000		67.00
				1.00	2.00	3.00
Inpatient Psychiatric Facility PPS						
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N		
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)				0	71.00
Inpatient Rehabilitation Facility PPS						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N		
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)				0	76.00
				1.00		
Long Term Care Hospital PPS						
80.00	Is this a Long Term Care Hospital (LTCH)? Enter "Y" for yes or "N" for no.			Y		
TEFRA Providers						
85.00	Is this a new hospital under 42 CFR section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N		
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	
Title V or XIX Inpatient Services						
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N	Y	
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		
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N		
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.			0.00	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		
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.			0.00	0.00	

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 152021	Period: From 07/01/2010 To 06/30/2011	Worksheet S-2 Part I Date/Time Prepared: 12/29/2011 10:42 am	
		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)				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)				107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		N		108.00
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.				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.				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	15H046	140.00
		1.00	2.00	3.00	
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.					
141.00	Name: ST. VINCENT HEALTH	Contractor's Name: NGS		Contractor's Number: 00130	
142.00	Street: 10330 N. MERIDIAN ST.	PO Box:			
143.00	City: INDIANAPOLIS	State: IN		Zip Code: 46290	
				1.00	
144.00	Are provider based physicians' costs included in worksheet A?		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 1.00	Part B 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 0	County 1.00	State 2.00	Zip Code 3.00	CBSA 4.00	FTE/Campus 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: 152021	Period: From 07/01/2010 To 06/30/2011	Worksheet S-2 Part II Date/Time Prepared: 12/29/2011 10:42 am
		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
		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: 152021	Period: From 07/01/2010 To 06/30/2011	Worksheet S-2 Part II Date/Time Prepared: 12/29/2011 10:42 am
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		Part A		
Description		Y/N	Date	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	2.00	21.00
				1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)				
Capital Related Cost				
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N		27.00
Interest Expense				
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	N		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N		31.00
Purchased Services				
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N		33.00
Provider-Based Physicians				
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	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: 152021

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

Worksheet S-2
Part II
Date/Time Prepared:
12/29/2011 10:42 am

		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: 152021

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

Worksheet S-3
Part I
Date/Time Prepared:
12/29/2011 10:42 am

Cost Center Description	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	
	Line Number				
	1.00	2.00	3.00	4.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	30	10,950	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)		30	10,950	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)		30	10,950	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)		30			27.00
28.00 Observation Bed Days					28.00
29.00 Ambulance Trips					29.00
30.00 Employee discount days (see instruction)					30.00
31.00 Employee discount days - IRF					31.00
32.00 Labor & delivery days (see instructions)					32.00
33.00 LTCH non-covered days					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 152021

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

Worksheet S-3
Part I
Date/Time Prepared:
12/29/2011 10:42 am

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	5,382	571	7,599		1.00
2.00 HMO		559	0			2.00
3.00 HMO IPF		0	0			3.00
4.00 HMO IRF		0	0			4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0	0		5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0		0	0		6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	0	5,382	571	7,599		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	5,382	571	7,599		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: 152021

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

Worksheet S-3
Part I
Date/Time Prepared:
12/29/2011 10:42 am

Cost Center Description	Full Time Equivalents			Discharges		
	Total Interns & Residents	Employees On Payroll	Nonpaid workers	Title V	Title XVIII	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, observation Bed and Hospice days)	9.00	10.00	11.00	12.00	13.00	1.00
2.00 HMO				0	182	2.00
3.00 HMO IPF					0	3.00
4.00 HMO IRF						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	95.11	0.00	0	182	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	95.11	0.00			27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

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	274		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	274		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: 152021	Period: From 07/01/2010 To 06/30/2011	Worksheet A Date/Time Prepared: 12/29/2011 10:42 am
Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
	1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS						
1.00		596,108	596,108	-38	596,070	1.00
2.00		390,373	390,373	0	390,373	2.00
3.00		0	0	0	0	3.00
4.00	83,524	1,650,267	1,733,791	0	1,733,791	4.00
5.00	915,824	749,814	1,665,638	38	1,665,676	5.00
6.00	0	0	0	0	0	6.00
7.00	60,721	72,079	132,800	0	132,800	7.00
8.00	0	0	0	0	0	8.00
9.00	0	53,985	53,985	0	53,985	9.00
10.00	0	121,346	121,346	0	121,346	10.00
11.00	0	0	0	0	0	11.00
12.00	0	0	0	0	0	12.00
13.00	349,629	9,304	358,933	0	358,933	13.00
14.00	0	0	0	0	0	14.00
15.00	427,045	766,846	1,193,891	0	1,193,891	15.00
16.00	27,766	25,888	53,654	0	53,654	16.00
17.00	56,695	349	57,044	0	57,044	17.00
18.00	48,684	651	49,335	0	49,335	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	3,171,735	630,069	3,801,804	0	3,801,804	30.00
ANCILLARY SERVICE COST CENTERS						
50.00	0	95,709	95,709	0	95,709	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	77	418,467	418,544	0	418,544	54.00
55.00	0	0	0	0	0	55.00
56.00	0	0	0	0	0	56.00
57.00	0	60,037	60,037	0	60,037	57.00
58.00	0	0	0	0	0	58.00
59.00	0	0	0	0	0	59.00
60.00	0	313,710	313,710	0	313,710	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	69,744	69,744	0	69,744	63.00
64.00	0	0	0	0	0	64.00
65.00	905,915	500,859	1,406,774	0	1,406,774	65.00
66.00	29,443	140,359	169,802	0	169,802	66.00
67.00	0	102,191	102,191	0	102,191	67.00
68.00	0	104,238	104,238	0	104,238	68.00
69.00	0	42,503	42,503	0	42,503	69.00
70.00	0	5,863	5,863	0	5,863	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	198,919	198,919	0	198,919	74.00
75.00	0	0	0	0	0	75.00
OTHER REIMBURSABLE COST CENTERS						
100.00	0	0	0	0	0	100.00
SPECIAL PURPOSE COST CENTERS						
118.00	6,077,058	7,119,678	13,196,736	0	13,196,736	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	6,077,058	7,119,678	13,196,736	0	13,196,736	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 152021

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

Worksheet A
Date/Time Prepared:
12/29/2011 10:42 am

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	147,105	743,175	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	390,373	2.00
3.00	OTHER CAP REL COSTS	0	0	3.00
4.00	EMPLOYEE BENEFITS	462,222	2,196,013	4.00
5.00	ADMINISTRATIVE & GENERAL	335,049	2,000,725	5.00
6.00	MAINTENANCE & REPAIRS	0	0	6.00
7.00	OPERATION OF PLANT	-859	131,941	7.00
8.00	LAUNDRY & LINEN SERVICE	0	0	8.00
9.00	HOUSEKEEPING	0	53,985	9.00
10.00	DIETARY	0	121,346	10.00
11.00	CAFETERIA	0	0	11.00
12.00	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	NURSING ADMINISTRATION	-498	358,435	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	14.00
15.00	PHARMACY	0	1,193,891	15.00
16.00	MEDICAL RECORDS & LIBRARY	-1,782	51,872	16.00
17.00	SOCIAL SERVICE	0	57,044	17.00
18.00	PASTORAL CARE	0	49,335	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	-2,610	3,799,194	30.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0	95,709	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	418,544	54.00
55.00	RADIOLOGY-THERAPEUTIC	0	0	55.00
56.00	RADIOISOTOPE	0	0	56.00
57.00	CT SCAN	0	60,037	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	59.00
60.00	LABORATORY	0	313,710	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	69,744	63.00
64.00	INTRAVENOUS THERAPY	0	0	64.00
65.00	RESPIRATORY THERAPY	0	1,406,774	65.00
66.00	PHYSICAL THERAPY	0	169,802	66.00
67.00	OCCUPATIONAL THERAPY	0	102,191	67.00
68.00	SPEECH PATHOLOGY	0	104,238	68.00
69.00	ELECTROCARDIOLOGY	0	42,503	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	5,863	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	198,919	74.00
75.00	ASC (NON-DISTINCT PART)	0	0	75.00
OTHER REIMBURSABLE COST CENTERS				
100.00	I&R SERVICES-NOT APPRVD PRGM	0	0	100.00
SPECIAL PURPOSE COST CENTERS				
118.00	SUBTOTALS (SUM OF LINES 1-117)	938,627	14,135,363	118.00
NONREIMBURSABLE COST CENTERS				
193.00	OTHER NONREIMBURSABLE COST CENTERS	0	0	193.00
193.01	MARKETING	175,344	175,344	193.01
200.00	TOTAL (SUM OF LINES 118-199)	1,113,971	14,310,707	200.00

RECLASSIFICATIONS

Provider CCN: 152021

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

Worksheet A-6

Date/Time Prepared:
12/29/2011 10:42 am

		Increases				
Cost Center		Line #	Salary	Other		
2.00		3.00	4.00	5.00		
A -- INTEREST						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	38		1.00
	TOTALS		0	38		
500.00	Grand Total: Increases		0	38		500.00

RECLASSIFICATIONS

Provider CCN: 152021

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

Worksheet A-6

Date/Time Prepared:
12/29/2011 10:42 am

		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	38	11		1.00	
	TOTALS		0	38				
500.00	Grand Total: Decreases		0	38			500.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 152021

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
12/29/2011 10:42 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	0	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	0	3.00
4.00	Building Improvements	827,832	17,266	0	17,266	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	1,043,615	25,007	0	25,007	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	1,871,447	42,273	0	42,273	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	1,871,447	42,273	0	42,273	0	10.00
SUMMARY OF CAPITAL							
Cost Center Description		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	177,848	416,060	142	2,058	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	85,355	305,018	0	0	0	2.00
3.00	Total (sum of lines 1-2)	263,203	721,078	142	2,058	0	3.00
COMPUTATION OF RATIOS							
Cost Center Description		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	845,098	0	845,098	0.441600	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,068,622	0	1,068,622	0.558400	0	2.00
3.00	Total (sum of lines 1-2)	1,913,720	0	1,913,720	1.000000	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 152021

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
12/29/2011 10:42 am

		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	0	0		1.00		
2.00	Land Improvements	0	0		2.00		
3.00	Buildings and Fixtures	0	0		3.00		
4.00	Building Improvements	845,098	0		4.00		
5.00	Fixed Equipment	0	0		5.00		
6.00	Movable Equipment	1,068,622	0		6.00		
7.00	HIT designated Assets	0	0		7.00		
8.00	Subtotal (sum of lines 1-7)	1,913,720	0		8.00		
9.00	Reconciling Items	0	0		9.00		
10.00	Total (line 8 minus line 9)	1,913,720	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	596,108		1.00		
2.00	CAP REL COSTS-MVBLE EQUIP	0	390,373		2.00		
3.00	Total (sum of lines 1-2)	0	986,481		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	325,022	416,060	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	85,355	305,018	2.00
3.00	Total (sum of lines 1-2)	0	0	0	410,377	721,078	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 152021

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
12/29/2011 10:42 am

Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	35	2,058	0	0	743,175	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	390,373	2.00
3.00	Total (sum of lines 1-2)	35	2,058	0	0	1,133,548	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 152021

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

Worksheet A-8

Date/Time Prepared:
12/29/2011 10:42 am

	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted	
			Cost Center	Line #
	1.00	2.00	3.00	4.00
1.00 Investment income - buildings and fixtures (chapter 2)	B	-104	CAP REL COSTS-BLDG & FIXT	1.00 1.00
2.00 Investment income - movable equipment (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00 2.00
3.00 Investment income - other (chapter 2)	B	-38	ADMINISTRATIVE & GENERAL	5.00 3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0		0.00 4.00
5.00 Refunds and rebates of expenses (chapter 8)		0		0.00 5.00
6.00 Rental of provider space by suppliers (chapter 8)		0		0.00 6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0		0.00 7.00
8.00 Television and radio service (chapter 21)		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		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	1,132,366		12.00
13.00 Laundry and linen service		0		0.00 13.00
14.00 Cafeteria-employees and guests		0		0.00 14.00
15.00 Rental of quarters to employee and others		0		0.00 15.00
16.00 Sale of medical and surgical supplies to other than patients		0		0.00 16.00
17.00 Sale of drugs to other than patients		0		0.00 17.00
18.00 Sale of medical records and abstracts	B	-1,782	MEDICAL RECORDS & LIBRARY	16.00 18.00
19.00 Nursing school (tuition, fees, books, etc.)		0		0.00 19.00
20.00 Vending machines		0		0.00 20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00 21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00 22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00 23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00 24.00
25.00 Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00 25.00
26.00 Depreciation - buildings and fixtures		0	CAP REL COSTS-BLDG & FIXT	1.00 26.00
27.00 Depreciation - movable equipment		0	CAP REL COSTS-MVBLE EQUIP	2.00 27.00
28.00 Non-physician Anesthetist		0	NONPHYSICIAN 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	OCCUPATIONAL THERAPY	67.00 30.00
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00 31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0		0.00 32.00
33.00 OTHER REV - CDM MAINTENANCE	B	-859	OPERATION OF PLANT	7.00 33.00
33.01 OTHER REV - FINANCIAL SERVICES	B	-1,783	ADMINISTRATIVE & GENERAL	5.00 33.01
33.03 LOBBYING - NALTH	A	-234	ADMINISTRATIVE & GENERAL	5.00 33.03
33.04 LOBBYING - OTHER	A	-683	ADMINISTRATIVE & GENERAL	5.00 33.04
33.05 CHARITY/DONATIONS	A	-4,305	ADMINISTRATIVE & GENERAL	5.00 33.05
33.06 CHARITY/DONATIONS	A	-475	NURSING ADMINISTRATION	13.00 33.06
33.07 MARKETING	A	-9	ADMINISTRATIVE & GENERAL	5.00 33.07
33.08 LOSS ON SALE OF ASSETS	A	-5,486	ADMINISTRATIVE & GENERAL	5.00 33.08
33.09 LOSS ON SALE OF ASSETS	A	-2,610	ADULTS & PEDIATRICS	30.00 33.09
33.10 NON-REIMBURSABLE ALCOHOL	A	-4	ADMINISTRATIVE & GENERAL	5.00 33.10
33.11 NON-REIMBURSABLE ALCOHOL	A	-23	NURSING ADMINISTRATION	13.00 33.11
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200.)		1,113,971		50.00

		Wkst. A-7 Ref.	
		5.00	
1.00	Investment income - buildings and fixtures (chapter 2)	9	1.00
2.00	Investment income - movable equipment (chapter 2)	0	2.00
3.00	Investment income - other (chapter 2)	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	0	7.00
8.00	Television and radio service (chapter 21)	0	8.00
9.00	Parking lot (chapter 21)	0	9.00
10.00	Provider-based physician adjustment	0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	0	11.00
12.00	Related organization transactions (chapter 10)	0	12.00
13.00	Laundry and linen service	0	13.00
14.00	Cafeteria-employees and guests	0	14.00
15.00	Rental of quarters to employee and others	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	0	16.00
17.00	Sale of drugs to other than patients	0	17.00
18.00	Sale of medical records and abstracts	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)	0	19.00
20.00	Vending machines	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		25.00
26.00	Depreciation - buildings and fixtures	0	26.00
27.00	Depreciation - movable equipment	0	27.00
28.00	Non-physician Anesthetist		28.00
29.00	Physicians' assistant	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)		30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	0	32.00
33.00	OTHER REV - CDM MAINTENANCE	0	33.00
33.01	OTHER REV - FINANCIAL SERVICES	0	33.01
33.03	LOBBYING - NALTH	0	33.03
33.04	LOBBYING - OTHER	0	33.04
33.05	CHARITY/DONATIONS	0	33.05
33.06	CHARITY/DONATIONS	0	33.06
33.07	MARKETING	0	33.07
33.08	LOSS ON SALE OF ASSETS	0	33.08
33.09	LOSS ON SALE OF ASSETS	0	33.09
33.10	NON-REIMBURSABLE ALCOHOL	0	33.10
33.11	NON-REIMBURSABLE ALCOHOL	0	33.11
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: 152021

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

Worksheet A-8-1

Date/Time Prepared: 12/29/2011 10:42 am

	Line No.	Cost Center	Expense Items	
	1.00	2.00	3.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	1.00	CAP REL COSTS-BLDG & FIXT	ST. JOSEPH BLDG RENT	1.00
2.00	4.00	EMPLOYEE BENEFITS	EMPLOYEE BENEFITS	2.00
3.00	4.00	EMPLOYEE BENEFITS	EMPLOYEE BENEFITS - CHARGEBACK	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	ADMIN - CHARGEBACK	4.00
4.01	7.00	OPERATION OF PLANT	ENGINEERING SVCS - CHARGEBACK	4.01
4.02	10.00	DIETARY	DIETARY - CHARGEBACK	4.02
4.03	15.00	PHARMACY	PHARMACY - CHARGEBACK	4.03
4.04	16.00	MEDICAL RECORDS & LIBRARY	MEDICAL RECORDS - CHARGEBACK	4.04
4.05	18.00	PASTORAL CARE	PASTORAL CARE - CHARGEBACK	4.05
4.06	30.00	ADULTS & PEDIATRICS	ADULT & 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	57.00	CT SCAN	CT SCAN - CHARGEBACK	4.09
4.10	60.00	LABORATORY	LAB - CHARGEBACK	4.10
4.11	63.00	BLOOD STORING, PROCESSING & TRANS.	BLOOD BANK - CHARGEBACK	4.11
4.12	65.00	RESPIRATORY THERAPY	RT - CHARGEBACK	4.12
4.13	66.00	PHYSICAL THERAPY	PT - CHARGEBACK	4.13
4.14	68.00	SPEECH PATHOLOGY	ST - CHARGEBACK	4.14
4.15	69.00	ELECTROCARDIOLOGY	EKG - CHARGEBACK	4.15
4.16	70.00	ELECTROENCEPHALOGRAPHY	EKG - CHARGEBACK	4.16
4.17	4.00	EMPLOYEE BENEFITS	ASCENSION BENEFITS	4.17
4.18	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE	4.18
4.19	193.01	MARKETING	HOME OFFICE	4.19
4.20	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	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
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to worksheet A-8, column 2, line 12.			5.00

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

Symbol (1)	Name	Percentage of Ownership
1.00	2.00	3.00

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

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

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

6.00	G	ST. VINCENT HEA	100.00	6.00
7.00	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:	HOME OFFICE		100.00

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

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

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

Provider CCN: 152021

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

Worksheet A-8-1

Date/Time Prepared: 12/29/2011 10:42 am

	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	416,060	416,060	0	10	1.00
2.00	1,029,307	567,085	462,222	0	2.00
3.00	32,720	32,720	0	0	3.00
4.00	73,862	73,862	0	0	4.00
4.01	190	190	0	0	4.01
4.02	121,722	121,722	0	0	4.02
4.03	29,891	29,891	0	0	4.03
4.04	39,822	39,822	0	0	4.04
4.05	48,684	48,684	0	0	4.05
4.06	50,474	50,474	0	0	4.06
4.07	93,287	93,287	0	0	4.07
4.08	418,176	418,176	0	0	4.08
4.09	60,037	60,037	0	0	4.09
4.10	112,557	112,557	0	0	4.10
4.11	69,744	69,744	0	0	4.11
4.12	135,477	135,477	0	0	4.12
4.13	138,194	138,194	0	0	4.13
4.14	104,239	104,239	0	0	4.14
4.15	42,503	42,503	0	0	4.15
4.16	5,863	5,863	0	0	4.16
4.17	314,184	314,184	0	0	4.17
4.18	147,278	0	147,278	9	4.18
4.19	175,344	0	175,344	0	4.19
4.20	1,090,751	743,135	347,616	0	4.20
4.21	35	104	-69	11	4.21
4.22	13	38	-25	0	4.22
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to worksheet A-8, column 2, line 12.	4,750,414	3,618,048	1,132,366	5.00

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

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

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

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

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

6.00	ST. VINCENT HEA ASCENSION	100.00	HOME OFFICE	6.00
7.00		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: 152021

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

Worksheet B
Part I
Date/Time Prepared:
12/29/2011 10:42 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	743,175	743,175			1.00
2.00	CAP REL COSTS-MVBLE EQUIP	390,373		390,373		2.00
4.00	EMPLOYEE BENEFITS	2,196,013	0	0	2,196,013	4.00
5.00	ADMINISTRATIVE & GENERAL	2,000,725	91,035	47,819	335,555	2,475,134
6.00	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	OPERATION OF PLANT	131,941	10,357	5,440	22,248	169,986
8.00	LAUNDRY & LINEN SERVICE	0	17,069	8,966	0	26,035
9.00	HOUSEKEEPING	53,985	5,114	2,686	0	61,785
10.00	DIETARY	121,346	20,521	10,779	0	152,646
11.00	CAFETERIA	0	0	0	0	11.00
12.00	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	NURSING ADMINISTRATION	358,435	42,001	22,062	128,103	550,601
14.00	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00	PHARMACY	1,193,891	32,796	17,227	156,468	1,400,382
16.00	MEDICAL RECORDS & LIBRARY	51,872	9,461	4,970	10,173	76,476
17.00	SOCIAL SERVICE	57,044	12,466	6,548	20,773	96,831
18.00	PASTORAL CARE	49,335	0	0	17,838	67,173
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	3,799,194	483,815	254,138	1,162,114	5,699,261
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	95,709	0	0	0	95,709
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	418,544	0	0	28	418,572
55.00	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
56.00	RADIOISOTOPE	0	0	0	0	56.00
57.00	CT SCAN	60,037	0	0	0	60,037
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	313,710	9,078	4,768	0	327,556
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.	69,744	0	0	0	69,744
64.00	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	1,406,774	7,416	3,895	331,925	1,750,010
66.00	PHYSICAL THERAPY	169,802	831	437	10,788	181,858
67.00	OCCUPATIONAL THERAPY	102,191	831	437	0	103,459
68.00	SPEECH PATHOLOGY	104,238	384	201	0	104,823
69.00	ELECTROCARDIOLOGY	42,503	0	0	0	42,503
70.00	ELECTROENCEPHALOGRAPHY	5,863	0	0	0	5,863
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	198,919	0	0	0	198,919
75.00	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
OTHER REIMBURSABLE COST CENTERS						
100.00	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	100.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	14,135,363	743,175	390,373	2,196,013	14,135,363
NONREIMBURSABLE COST CENTERS						
193.00	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	193.00
193.01	MARKETING	175,344	0	0	0	175,344
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)	14,310,707	743,175	390,373	2,196,013	14,310,707

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COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 152021

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

Worksheet B
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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	2,475,134					5.00
6.00	MAINTENANCE & REPAIRS	0	0				6.00
7.00	OPERATION OF PLANT	35,549	0	205,535			7.00
8.00	LAUNDRY & LINEN SERVICE	5,445	0	5,466	36,946		8.00
9.00	HOUSEKEEPING	12,921	0	1,638	0	76,344	9.00
10.00	DIETARY	31,922	0	6,572	0	2,529	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	115,146	0	13,451	0	5,175	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	PHARMACY	292,858	0	10,503	0	4,041	15.00
16.00	MEDICAL RECORDS & LIBRARY	15,993	0	3,030	0	1,166	16.00
17.00	SOCIAL SERVICE	20,250	0	3,992	0	1,536	17.00
18.00	PASTORAL CARE	14,048	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	1,191,866	0	154,946	36,946	59,613	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	20,015	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	87,535	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	12,555	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	68,501	0	2,907	0	1,119	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.	14,585	0	0	0	0	63.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	365,974	0	2,375	0	914	65.00
66.00	PHYSICAL THERAPY	38,031	0	266	0	102	66.00
67.00	OCCUPATIONAL THERAPY	21,636	0	266	0	102	67.00
68.00	SPEECH PATHOLOGY	21,921	0	123	0	47	68.00
69.00	ELECTROCARDIOLOGY	8,889	0	0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	1,226	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	41,599	0	0	0	0	74.00
75.00	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
OTHER REIMBURSABLE COST CENTERS							
100.00	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	2,438,465	0	205,535	36,946	76,344	118.00
NONREIMBURSABLE COST CENTERS							
193.00	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	193.00
193.01	MARKETING	36,669	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)	2,475,134	0	205,535	36,946	76,344	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 152021

Period:
From 07/01/2010
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	193,669					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	684,373		13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	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
18.00	PASTORAL CARE	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	193,669	0	0	536,023	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	137,953	0	65.00
66.00	PHYSICAL THERAPY	0	0	0	10,397	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
OTHER REIMBURSABLE COST CENTERS							
100.00	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	193,669	0	0	684,373	0	118.00
NONREIMBURSABLE COST CENTERS							
193.00	OTHER NONREIMBURSABLE COST CENTERS	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	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	193,669	0	0	684,373	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 152021

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

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Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE		NONPHYSICIAN ANESTHETISTS	
				PASTORAL CARE			
	15.00	16.00	17.00	18.00	19.00		
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	1,707,784						15.00
16.00 MEDICAL RECORDS & LIBRARY	0	96,665					16.00
17.00 SOCIAL SERVICE	0	0	122,609				17.00
18.00 PASTORAL CARE	0	0	0	81,221			18.00
19.00 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	0	19.00
20.00 NURSING SCHOOL	0	0	0	0	0	0	20.00
21.00 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	0	21.00
22.00 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	0	22.00
23.00 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 ADULTS & PEDIATRICS	0	36,380	122,609	81,221	0	0	30.00
ANCILLARY SERVICE COST CENTERS							
50.00 OPERATING ROOM	0	2,889	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	3,194	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	1,588	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	11,033	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	653	0	0	0	0	63.00
64.00 INTRAVENOUS THERAPY	0	0	0	0	0	0	64.00
65.00 RESPIRATORY THERAPY	0	17,998	0	0	0	0	65.00
66.00 PHYSICAL THERAPY	0	2,060	0	0	0	0	66.00
67.00 OCCUPATIONAL THERAPY	0	1,972	0	0	0	0	67.00
68.00 SPEECH PATHOLOGY	0	865	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	0	900	0	0	0	0	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	31	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	1,707,784	14,282	0	0	0	0	73.00
74.00 RENAL DIALYSIS	0	2,820	0	0	0	0	74.00
75.00 ASC (NON-DISTINCT PART)	0	0	0	0	0	0	75.00
OTHER REIMBURSABLE COST CENTERS							
100.00 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	0	100.00
SPECIAL PURPOSE COST CENTERS							
118.00 SUBTOTALS (SUM OF LINES 1-117)	1,707,784	96,665	122,609	81,221	0	0	118.00
NONREIMBURSABLE COST CENTERS							
193.00 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	0	193.00
193.01 MARKETING	0	0	0	0	0	0	193.01
200.00 Cross Foot Adjustments	0	0	0	0	0	0	200.00
201.00 Negative Cost Centers	0	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	1,707,784	96,665	122,609	81,221	0	0	202.00

Cost Center Description	INTERNS & RESIDENTS				PARAMED ED PRGM	Subtotal	
	NURSING SCHOOL	SERVICES-SALAR	SERVICES-OTHER	PRGM COSTS			
		Y & FRINGES					
20.00	21.00	22.00	23.00	24.00			
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
18.00							18.00
19.00							19.00
20.00	0						20.00
21.00	0	0					21.00
22.00	0	0	0				22.00
23.00	0	0	0	0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	0	0	0	0	0	8,112,534	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	0	0	0	0	0	118,613	50.00
51.00	0	0	0	0	0	0	51.00
52.00	0	0	0	0	0	0	52.00
53.00	0	0	0	0	0	0	53.00
54.00	0	0	0	0	0	509,301	54.00
55.00	0	0	0	0	0	0	55.00
56.00	0	0	0	0	0	0	56.00
57.00	0	0	0	0	0	74,180	57.00
58.00	0	0	0	0	0	0	58.00
59.00	0	0	0	0	0	0	59.00
60.00	0	0	0	0	0	411,116	60.00
60.01	0	0	0	0	0	0	60.01
61.00	0	0	0	0	0	0	61.00
62.00	0	0	0	0	0	0	62.00
63.00	0	0	0	0	0	84,982	63.00
64.00	0	0	0	0	0	0	64.00
65.00	0	0	0	0	0	2,275,224	65.00
66.00	0	0	0	0	0	232,714	66.00
67.00	0	0	0	0	0	127,435	67.00
68.00	0	0	0	0	0	127,779	68.00
69.00	0	0	0	0	0	52,292	69.00
70.00	0	0	0	0	0	7,120	70.00
71.00	0	0	0	0	0	0	71.00
72.00	0	0	0	0	0	0	72.00
73.00	0	0	0	0	0	1,722,066	73.00
74.00	0	0	0	0	0	243,338	74.00
75.00	0	0	0	0	0	0	75.00
OTHER REIMBURSABLE COST CENTERS							
100.00	0	0	0	0	0	0	100.00
SPECIAL PURPOSE COST CENTERS							
118.00	0	0	0	0	0	14,098,694	118.00
NONREIMBURSABLE COST CENTERS							
193.00	0	0	0	0	0	0	193.00
193.01	0	0	0	0	0	212,013	193.01
200.00	0	0	0	0	0	0	200.00
201.00	0	0	0	0	0	0	201.00
202.00	0	0	0	0	0	14,310,707	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 152021

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

Worksheet B
Part I
Date/Time Prepared:
12/29/2011 10:42 am

Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT			1.00
2.00	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	EMPLOYEE BENEFITS			4.00
5.00	ADMINISTRATIVE & GENERAL			5.00
6.00	MAINTENANCE & REPAIRS			6.00
7.00	OPERATION OF PLANT			7.00
8.00	LAUNDRY & LINEN SERVICE			8.00
9.00	HOUSEKEEPING			9.00
10.00	DIETARY			10.00
11.00	CAFETERIA			11.00
12.00	MAINTENANCE OF PERSONNEL			12.00
13.00	NURSING ADMINISTRATION			13.00
14.00	CENTRAL SERVICES & SUPPLY			14.00
15.00	PHARMACY			15.00
16.00	MEDICAL RECORDS & LIBRARY			16.00
17.00	SOCIAL SERVICE			17.00
18.00	PASTORAL CARE			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)			23.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	0	8,112,534	30.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	0	118,613	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	509,301	54.00
55.00	RADIOLOGY-THERAPEUTIC	0	0	55.00
56.00	RADIOISOTOPE	0	0	56.00
57.00	CT SCAN	0	74,180	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	59.00
60.00	LABORATORY	0	411,116	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	84,982	63.00
64.00	INTRAVENOUS THERAPY	0	0	64.00
65.00	RESPIRATORY THERAPY	0	2,275,224	65.00
66.00	PHYSICAL THERAPY	0	232,714	66.00
67.00	OCCUPATIONAL THERAPY	0	127,435	67.00
68.00	SPEECH PATHOLOGY	0	127,779	68.00
69.00	ELECTROCARDIOLOGY	0	52,292	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	7,120	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	1,722,066	73.00
74.00	RENAL DIALYSIS	0	243,338	74.00
75.00	ASC (NON-DISTINCT PART)	0	0	75.00
OTHER REIMBURSABLE COST CENTERS				
100.00	I&R SERVICES-NOT APPRVD PRGM	0	0	100.00
SPECIAL PURPOSE COST CENTERS				
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	14,098,694	118.00
NONREIMBURSABLE COST CENTERS				
193.00	OTHER NONREIMBURSABLE COST CENTERS	0	0	193.00
193.01	MARKETING	0	212,013	193.01
200.00	Cross Foot Adjustments	0	0	200.00
201.00	Negative Cost Centers	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	14,310,707	202.00

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ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 152021

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

Worksheet B
Part II
Date/Time Prepared:
12/29/2011 10:42 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	EMPLOYEE BENEFITS	0	0	0	0	4.00
5.00	ADMINISTRATIVE & GENERAL	0	91,035	47,819	138,854	5.00
6.00	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	OPERATION OF PLANT	0	10,357	5,440	15,797	7.00
8.00	LAUNDRY & LINEN SERVICE	0	17,069	8,966	26,035	8.00
9.00	HOUSEKEEPING	0	5,114	2,686	7,800	9.00
10.00	DIETARY	0	20,521	10,779	31,300	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	42,001	22,062	64,063	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00	PHARMACY	0	32,796	17,227	50,023	15.00
16.00	MEDICAL RECORDS & LIBRARY	0	9,461	4,970	14,431	16.00
17.00	SOCIAL SERVICE	0	12,466	6,548	19,014	17.00
18.00	PASTORAL CARE	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	483,815	254,138	737,953	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	9,078	4,768	13,846	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	7,416	3,895	11,311	65.00
66.00	PHYSICAL THERAPY	0	831	437	1,268	66.00
67.00	OCCUPATIONAL THERAPY	0	831	437	1,268	67.00
68.00	SPEECH PATHOLOGY	0	384	201	585	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
OTHER REIMBURSABLE COST CENTERS						
100.00	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	100.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	743,175	390,373	1,133,548	118.00
NONREIMBURSABLE COST CENTERS						
193.00	OTHER NONREIMBURSABLE COST CENTERS	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	743,175	390,373	1,133,548	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 152021		Period: From 07/01/2010 To 06/30/2011		Worksheet B Part II Date/Time Prepared: 12/29/2011 10:42 am	
Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING		
	5.00	6.00	7.00	8.00	9.00		
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL	138,854					5.00
6.00	MAINTENANCE & REPAIRS	0	0				6.00
7.00	OPERATION OF PLANT	1,994	0	17,791			7.00
8.00	LAUNDRY & LINEN SERVICE	305	0	473	26,813		8.00
9.00	HOUSEKEEPING	725	0	142	0	8,667	9.00
10.00	DIETARY	1,791	0	569	0	287	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	6,460	0	1,164	0	588	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	PHARMACY	16,429	0	909	0	459	15.00
16.00	MEDICAL RECORDS & LIBRARY	897	0	262	0	132	16.00
17.00	SOCIAL SERVICE	1,136	0	346	0	174	17.00
18.00	PASTORAL CARE	788	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	66,862	0	13,411	26,813	6,767	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	1,123	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	4,911	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	704	0	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	LABORATORY	3,843	0	252	0	127	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.	818	0	0	0	0	63.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	20,531	0	206	0	104	65.00
66.00	PHYSICAL THERAPY	2,134	0	23	0	12	66.00
67.00	OCCUPATIONAL THERAPY	1,214	0	23	0	12	67.00
68.00	SPEECH PATHOLOGY	1,230	0	11	0	5	68.00
69.00	ELECTROCARDIOLOGY	499	0	0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	69	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	2,334	0	0	0	0	74.00
75.00	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
OTHER REIMBURSABLE COST CENTERS							
100.00	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	136,797	0	17,791	26,813	8,667	118.00
NONREIMBURSABLE COST CENTERS							
193.00	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	193.00
193.01	MARKETING	2,057	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)	138,854	0	17,791	26,813	8,667	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 152021

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

Worksheet B
Part II
Date/Time Prepared:
12/29/2011 10:42 am

Cost Center Description		DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
		10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	EMPLOYEE BENEFITS						4.00
5.00	ADMINISTRATIVE & GENERAL						5.00
6.00	MAINTENANCE & REPAIRS						6.00
7.00	OPERATION OF PLANT						7.00
8.00	LAUNDRY & LINEN SERVICE						8.00
9.00	HOUSEKEEPING						9.00
10.00	DIETARY	33,947					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	72,275		13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	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
18.00	PASTORAL CARE	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	33,947	0	0	56,608	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	14,569	0	65.00
66.00	PHYSICAL THERAPY	0	0	0	1,098	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
OTHER REIMBURSABLE COST CENTERS							
100.00	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	33,947	0	0	72,275	0	118.00
NONREIMBURSABLE COST CENTERS							
193.00	OTHER NONREIMBURSABLE COST CENTERS	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	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	33,947	0	0	72,275	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 152021

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

Worksheet B
Part II
Date/Time Prepared:
12/29/2011 10:42 am

Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE PASTORAL CARE	NONPHYSICIAN ANESTHETISTS	
	15.00	16.00	17.00	18.00	19.00	
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	67,820					15.00
16.00 MEDICAL RECORDS & LIBRARY	0	15,722				16.00
17.00 SOCIAL SERVICE	0	0	20,670			17.00
18.00 PASTORAL CARE	0	0	0	788		18.00
19.00 NONPHYSICIAN ANESTHETISTS	0	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	5,918	20,670	788		30.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	470	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	519	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	258	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	1,794	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	106	0	0		63.00
64.00 INTRAVENOUS THERAPY	0	0	0	0		64.00
65.00 RESPIRATORY THERAPY	0	2,927	0	0		65.00
66.00 PHYSICAL THERAPY	0	335	0	0		66.00
67.00 OCCUPATIONAL THERAPY	0	321	0	0		67.00
68.00 SPEECH PATHOLOGY	0	141	0	0		68.00
69.00 ELECTROCARDIOLOGY	0	146	0	0		69.00
70.00 ELECTROENCEPHALOGRAPHY	0	5	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	67,820	2,323	0	0		73.00
74.00 RENAL DIALYSIS	0	459	0	0		74.00
75.00 ASC (NON-DISTINCT PART)	0	0	0	0		75.00
OTHER REIMBURSABLE COST CENTERS						
100.00 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0		100.00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1-117)	67,820	15,722	20,670	788	0	118.00
NONREIMBURSABLE COST CENTERS						
193.00 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0		193.00
193.01 MARKETING	0	0	0	0		193.01
200.00 Cross Foot Adjustments						0 200.00
201.00 Negative Cost Centers	0	0	0	0		0 201.00
202.00 TOTAL (sum lines 118-201)	67,820	15,722	20,670	788	0	0 202.00

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ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 152021

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

Worksheet B
Part II
Date/Time Prepared:
12/29/2011 10:42 am

Cost Center Description	INTERNS & RESIDENTS				Subtotal	
	NURSING SCHOOL	SERVICES-SALAR	SERVICES-OTHER	PARAMED ED		
		Y & FRINGES	PRGM COSTS	PRGM		
20.00	21.00	22.00	23.00	24.00		
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
18.00						18.00
19.00						19.00
20.00						20.00
21.00	0	0				21.00
22.00			0			22.00
23.00				0		23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00					969,737	30.00
ANCILLARY SERVICE COST CENTERS						
50.00					1,593	50.00
51.00					0	51.00
52.00					0	52.00
53.00					0	53.00
54.00					5,430	54.00
55.00					0	55.00
56.00					0	56.00
57.00					962	57.00
58.00					0	58.00
59.00					0	59.00
60.00					19,862	60.00
60.01					0	60.01
61.00					0	61.00
62.00					0	62.00
63.00					924	63.00
64.00					0	64.00
65.00					49,648	65.00
66.00					4,870	66.00
67.00					2,838	67.00
68.00					1,972	68.00
69.00					645	69.00
70.00					74	70.00
71.00					0	71.00
72.00					0	72.00
73.00					70,143	73.00
74.00					2,793	74.00
75.00					0	75.00
OTHER REIMBURSABLE COST CENTERS						
100.00					0	100.00
SPECIAL PURPOSE COST CENTERS						
118.00	0	0	0	0	1,131,491	118.00
NONREIMBURSABLE COST CENTERS						
193.00					0	193.00
193.01					2,057	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	1,133,548	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 152021

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

Worksheet B
Part II
Date/Time Prepared:
12/29/2011 10:42 am

Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	25.00	26.00	
GENERAL SERVICE COST CENTERS			
1.00 CAP REL COSTS-BLDG & FIXT			1.00
2.00 CAP REL COSTS-MVBLE EQUIP			2.00
4.00 EMPLOYEE BENEFITS			4.00
5.00 ADMINISTRATIVE & GENERAL			5.00
6.00 MAINTENANCE & REPAIRS			6.00
7.00 OPERATION OF PLANT			7.00
8.00 LAUNDRY & LINEN SERVICE			8.00
9.00 HOUSEKEEPING			9.00
10.00 DIETARY			10.00
11.00 CAFETERIA			11.00
12.00 MAINTENANCE OF PERSONNEL			12.00
13.00 NURSING ADMINISTRATION			13.00
14.00 CENTRAL SERVICES & SUPPLY			14.00
15.00 PHARMACY			15.00
16.00 MEDICAL RECORDS & LIBRARY			16.00
17.00 SOCIAL SERVICE			17.00
18.00 PASTORAL CARE			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)			23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00 ADULTS & PEDIATRICS	0	969,737	30.00
ANCILLARY SERVICE COST CENTERS			
50.00 OPERATING ROOM	0	1,593	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	5,430	54.00
55.00 RADIOLOGY-THERAPEUTIC	0	0	55.00
56.00 RADIOISOTOPE	0	0	56.00
57.00 CT SCAN	0	962	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	59.00
60.00 LABORATORY	0	19,862	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	924	63.00
64.00 INTRAVENOUS THERAPY	0	0	64.00
65.00 RESPIRATORY THERAPY	0	49,648	65.00
66.00 PHYSICAL THERAPY	0	4,870	66.00
67.00 OCCUPATIONAL THERAPY	0	2,838	67.00
68.00 SPEECH PATHOLOGY	0	1,972	68.00
69.00 ELECTROCARDIOLOGY	0	645	69.00
70.00 ELECTROENCEPHALOGRAPHY	0	74	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	70,143	73.00
74.00 RENAL DIALYSIS	0	2,793	74.00
75.00 ASC (NON-DISTINCT PART)	0	0	75.00
OTHER REIMBURSABLE COST CENTERS			
100.00 I&R SERVICES-NOT APPRVD PRGM	0	0	100.00
SPECIAL PURPOSE COST CENTERS			
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	1,131,491	118.00
NONREIMBURSABLE COST CENTERS			
193.00 OTHER NONREIMBURSABLE COST CENTERS	0	0	193.00
193.01 MARKETING	0	2,057	193.01
200.00 Cross Foot Adjustments	0	0	200.00
201.00 Negative Cost Centers	0	0	201.00
202.00 TOTAL (sum lines 118-201)	0	1,133,548	202.00

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCU. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)					
	1.00	2.00	4.00				
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	11,625					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		11,625				2.00
4.00	EMPLOYEE BENEFITS	0	0	5,993,534			4.00
5.00	ADMINISTRATIVE & GENERAL	1,424	1,424	915,824	-2,475,134	11,835,573	5.00
6.00	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	OPERATION OF PLANT	162	162	60,721	0	169,986	7.00
8.00	LAUNDRY & LINEN SERVICE	267	267	0	0	26,035	8.00
9.00	HOUSEKEEPING	80	80	0	0	61,785	9.00
10.00	DIETARY	321	321	0	0	152,646	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	657	657	349,629	0	550,601	13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	PHARMACY	513	513	427,045	0	1,400,382	15.00
16.00	MEDICAL RECORDS & LIBRARY	148	148	27,766	0	76,476	16.00
17.00	SOCIAL SERVICE	195	195	56,695	0	96,831	17.00
18.00	PASTORAL CARE	0	0	48,684	0	67,173	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	7,568	7,568	3,171,735	0	5,699,261	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	0	0	0	0	95,709	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	77	0	418,572	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	60,037	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	142	142	0	0	327,556	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	69,744	63.00
64.00	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	RESPIRATORY THERAPY	116	116	905,915	0	1,750,010	65.00
66.00	PHYSICAL THERAPY	13	13	29,443	0	181,858	66.00
67.00	OCCUPATIONAL THERAPY	13	13	0	0	103,459	67.00
68.00	SPEECH PATHOLOGY	6	6	0	0	104,823	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	0	42,503	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	5,863	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	198,919	74.00
75.00	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
OTHER REIMBURSABLE COST CENTERS							
100.00	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	11,625	11,625	5,993,534	-2,475,134	11,660,229	118.00
NONREIMBURSABLE COST CENTERS							
193.00	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	193.00
193.01	MARKETING	0	0	0	0	175,344	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)	743,175	390,373	2,196,013		2,475,134	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	63.929032	33.580473	0.366397		0.209127	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			0		138,854	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000000		0.011732	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 152021

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

Worksheet B-1

Date/Time Prepared:
12/29/2011 10:42 am

Cost Center Description	MAINTENANCE & REPAIRS (SQARE FEET)	OPERATION OF PLANT (SQARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	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	10,039				7.00
8.00 LAUNDRY & LINEN SERVICE	0	267	100			8.00
9.00 HOUSEKEEPING	0	80	0	9,692		9.00
10.00 DIETARY	0	321	0	321	7,599	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	657	0	657	0	13.00
14.00 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00 PHARMACY	0	513	0	513	0	15.00
16.00 MEDICAL RECORDS & LIBRARY	0	148	0	148	0	16.00
17.00 SOCIAL SERVICE	0	195	0	195	0	17.00
18.00 PASTORAL CARE	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	7,568	100	7,568	7,599	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	142	0	142	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	116	0	116	0	65.00
66.00 PHYSICAL THERAPY	0	13	0	13	0	66.00
67.00 OCCUPATIONAL THERAPY	0	13	0	13	0	67.00
68.00 SPEECH PATHOLOGY	0	6	0	6	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
OTHER REIMBURSABLE COST CENTERS						
100.00 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	10,039	100	9,692	7,599	118.00
NONREIMBURSABLE COST CENTERS						
193.00 OTHER NONREIMBURSABLE COST CENTERS	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	205,535	36,946	76,344	193,669	202.00
203.00 Unit cost multiplier (wkst. B, Part I)	0.000000	20.473653	369.460000	7.877012	25.486117	203.00
204.00 Cost to be allocated (per wkst. B, Part II)	0	17,791	26,813	8,667	33,947	204.00
205.00 Unit cost multiplier (wkst. B, Part II)	0.000000	1.772188	268.130000	0.894243	4.467298	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 152021

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

Worksheet B-1

Date/Time Prepared:
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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	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	0					11.00
12.00	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	NURSING ADMINISTRATION	0	0	140,210			13.00
14.00	CENTRAL SERVICES & SUPPLY	0	0	0	100		14.00
15.00	PHARMACY	0	0	0	0	100	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
18.00	PASTORAL CARE	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	0	109,817	0	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	28,263	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	2,130	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	100	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	100	73.00
74.00	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
OTHER REIMBURSABLE COST CENTERS							
100.00	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	0	140,210	100	100	118.00
NONREIMBURSABLE COST CENTERS							
193.00	OTHER NONREIMBURSABLE COST CENTERS	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	0	684,373	0	1,707,784	202.00
203.00	Unit cost multiplier (wkst. B, Part I)	0.000000	0.000000	4.881057	0.000000	17,077.840000	203.00
204.00	Cost to be allocated (per wkst. B, Part II)	0	0	72,275	0	67,820	204.00
205.00	Unit cost multiplier (wkst. B, Part II)	0.000000	0.000000	0.515477	0.000000	678.200000	205.00

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COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 152021

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

Worksheet B-1

Date/Time Prepared:
12/29/2011 10:42 am

Cost Center Description	MEDICAL RECORDS & LIBRARY (REVENUE)	SOCIAL SERVICE (PATIENT DAYS)	OTHER GENERAL SERVICE	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	
			PASTORAL CARE (PATIENT DAYS)			
	16.00	17.00	18.00	19.00	20.00	
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	32,478,223					16.00
17.00	0	7,599				17.00
18.00	0	0	7,599			18.00
19.00	0	0	0	0		19.00
20.00	0	0	0	0	0	20.00
21.00	0	0	0	0		21.00
22.00	0	0	0	0		22.00
23.00	0	0	0	0		23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	12,221,582	7,599	7,599			30.00
ANCILLARY SERVICE COST CENTERS						
50.00	970,620	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	1,073,142	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	533,597	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	3,707,341	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	219,428	0	0	0	0	63.00
64.00	0	0	0	0	0	64.00
65.00	6,047,871	0	0	0	0	65.00
66.00	692,145	0	0	0	0	66.00
67.00	662,526	0	0	0	0	67.00
68.00	290,519	0	0	0	0	68.00
69.00	302,484	0	0	0	0	69.00
70.00	10,371	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	4,799,133	0	0	0	0	73.00
74.00	947,464	0	0	0	0	74.00
75.00	0	0	0	0	0	75.00
OTHER REIMBURSABLE COST CENTERS						
100.00	0	0	0	0	0	100.00
SPECIAL PURPOSE COST CENTERS						
118.00	32,478,223	7,599	7,599	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	96,665	122,609	81,221	0	0	202.00
203.00	0.002976	16.134886	10.688380	0.000000	0.000000	203.00
204.00	15,722	20,670	788	0	0	204.00
205.00	0.000484	2.720095	0.103698	0.000000	0.000000	205.00

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Cost Center Description	INTERNS & RESIDENTS			PARAMED PRGM (ASSIGNED TIME)	
	SERVICES-SALARY & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)			
	21.00	22.00	23.00		
GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT				1.00
2.00	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	EMPLOYEE BENEFITS				4.00
5.00	ADMINISTRATIVE & GENERAL				5.00
6.00	MAINTENANCE & REPAIRS				6.00
7.00	OPERATION OF PLANT				7.00
8.00	LAUNDRY & LINEN SERVICE				8.00
9.00	HOUSEKEEPING				9.00
10.00	DIETARY				10.00
11.00	CAFETERIA				11.00
12.00	MAINTENANCE OF PERSONNEL				12.00
13.00	NURSING ADMINISTRATION				13.00
14.00	CENTRAL SERVICES & SUPPLY				14.00
15.00	PHARMACY				15.00
16.00	MEDICAL RECORDS & LIBRARY				16.00
17.00	SOCIAL SERVICE				17.00
18.00	PASTORAL CARE				18.00
19.00	NONPHYSICIAN ANESTHETISTS				19.00
20.00	NURSING SCHOOL				20.00
21.00	I&R SERVICES-SALARY & FRINGES APPRVD	0			21.00
22.00	I&R SERVICES-OTHER PRGM COSTS APPRVD		0		22.00
23.00	PARAMED ED PRGM-(SPECIFY)			0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS	0	0	0	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0	0	0	50.00
51.00	RECOVERY ROOM	0	0	0	51.00
52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	ANESTHESIOLOGY	0	0	0	53.00
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
55.00	RADIOLOGY-THERAPEUTIC	0	0	0	55.00
56.00	RADIOISOTOPE	0	0	0	56.00
57.00	CT SCAN	0	0	0	57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00	CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	LABORATORY	0	0	0	60.00
60.01	BLOOD LABORATORY	0	0	0	60.01
61.00	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0	0	0	63.00
64.00	INTRAVENOUS THERAPY	0	0	0	64.00
65.00	RESPIRATORY THERAPY	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	68.00
69.00	ELECTROCARDIOLOGY	0	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	73.00
74.00	RENAL DIALYSIS	0	0	0	74.00
75.00	ASC (NON-DISTINCT PART)	0	0	0	75.00
OTHER REIMBURSABLE COST CENTERS					
100.00	I&R SERVICES-NOT APPRVD PRGM	0	0	0	100.00
SPECIAL PURPOSE COST CENTERS					
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	0	0	118.00
NONREIMBURSABLE COST CENTERS					
193.00	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	193.00
193.01	MARKETING	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	0	0	202.00
203.00	Unit cost multiplier (wkst. B, Part I)	0.000000	0.000000	0.000000	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	0	0	0	204.00
205.00	Unit cost multiplier (wkst. B, Part II)	0.000000	0.000000	0.000000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 152021	Period: From 07/01/2010 To 06/30/2011	Worksheet C Part I Date/Time Prepared: 12/29/2011 10:42 am
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Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	Hospital		
				RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	8,112,534		8,112,534	0	8,112,534	30.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	118,613		118,613	0	118,613	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	509,301		509,301	0	509,301	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	74,180		74,180	0	74,180	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	411,116		411,116	0	411,116	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.	84,982		84,982	0	84,982	63.00
64.00 INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00 RESPIRATORY THERAPY	2,275,224	0	2,275,224	0	2,275,224	65.00
66.00 PHYSICAL THERAPY	232,714	0	232,714	0	232,714	66.00
67.00 OCCUPATIONAL THERAPY	127,435	0	127,435	0	127,435	67.00
68.00 SPEECH PATHOLOGY	127,779	0	127,779	0	127,779	68.00
69.00 ELECTROCARDIOLOGY	52,292		52,292	0	52,292	69.00
70.00 ELECTROENCEPHALOGRAPHY	7,120		7,120	0	7,120	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	1,722,066		1,722,066	0	1,722,066	73.00
74.00 RENAL DIALYSIS	243,338		243,338	0	243,338	74.00
75.00 ASC (NON-DISTINCT PART)	0		0	0	0	75.00
OTHER REIMBURSABLE COST CENTERS						
100.00 I&R SERVICES-NOT APPRVD PRGM	0		0	0	0	100.00
200.00 Subtotal (see instructions)	14,098,694	0	14,098,694	0	14,098,694	200.00
201.00 Less Observation Beds	0		0	0	0	201.00
202.00 Total (see instructions)	14,098,694	0	14,098,694	0	14,098,694	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 152021

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

Worksheet C
Part I
Date/Time Prepared:
12/29/2011 10:42 am

		Title XVIII			Hospital	PPS	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	12,221,582		12,221,582			30.00
ANCILLARY SERVICE COST CENTERS							
50.00	OPERATING ROOM	970,620	0	970,620	0.122203	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	1,071,627	1,515	1,073,142	0.474589	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	525,665	7,932	533,597	0.139019	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	3,706,722	619	3,707,341	0.110892	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.	219,428	0	219,428	0.387289	0.000000	63.00
64.00	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
65.00	RESPIRATORY THERAPY	6,024,602	23,269	6,047,871	0.376202	0.000000	65.00
66.00	PHYSICAL THERAPY	692,145	0	692,145	0.336221	0.000000	66.00
67.00	OCCUPATIONAL THERAPY	662,526	0	662,526	0.192347	0.000000	67.00
68.00	SPEECH PATHOLOGY	290,416	103	290,519	0.439830	0.000000	68.00
69.00	ELECTROCARDIOLOGY	302,172	312	302,484	0.172875	0.000000	69.00
70.00	ELECTROENCEPHALOGRAPHY	10,371	0	10,371	0.686530	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	4,799,133	0	4,799,133	0.358829	0.000000	73.00
74.00	RENAL DIALYSIS	947,464	0	947,464	0.256831	0.000000	74.00
75.00	ASC (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	75.00
OTHER REIMBURSABLE COST CENTERS							
100.00	I&R SERVICES-NOT APPRVD PRGM	0	0	0			100.00
200.00	Subtotal (see instructions)	32,444,473	33,750	32,478,223			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	32,444,473	33,750	32,478,223			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 152021

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

Worksheet C
Part I
Date/Time Prepared:
12/29/2011 10:42 am

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.122203			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	0.474589			54.00
55.00	RADIOLOGY-THERAPEUTIC	0.000000			55.00
56.00	RADIOISOTOPE	0.000000			56.00
57.00	CT SCAN	0.139019			57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	0.000000			58.00
59.00	CARDIAC CATHETERIZATION	0.000000			59.00
60.00	LABORATORY	0.110892			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.	0.387289			63.00
64.00	INTRAVENOUS THERAPY	0.000000			64.00
65.00	RESPIRATORY THERAPY	0.376202			65.00
66.00	PHYSICAL THERAPY	0.336221			66.00
67.00	OCCUPATIONAL THERAPY	0.192347			67.00
68.00	SPEECH PATHOLOGY	0.439830			68.00
69.00	ELECTROCARDIOLOGY	0.172875			69.00
70.00	ELECTROENCEPHALOGRAPHY	0.686530			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	0.358829			73.00
74.00	RENAL DIALYSIS	0.256831			74.00
75.00	ASC (NON-DISTINCT PART)	0.000000			75.00
OTHER REIMBURSABLE COST CENTERS					
100.00	I&R SERVICES-NOT APPRVD PRGM				100.00
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: 152021

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

Worksheet C
Part I
Date/Time Prepared:
12/29/2011 10:42 am

Cost Center Description	Total Cost (from wkst. B, Part I, col. 26)	Therapy Limit Adj.	Title XIX		Hospital		Total Costs
			Total Costs	RCE Disallowance	Total Costs	Cost	
			1.00	2.00	3.00	4.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 ADULTS & PEDIATRICS	8,112,534		8,112,534	0		0	30.00
ANCILLARY SERVICE COST CENTERS							
50.00 OPERATING ROOM	118,613		118,613	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	509,301		509,301	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	74,180		74,180	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	411,116		411,116	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.	84,982		84,982	0		0	63.00
64.00 INTRAVENOUS THERAPY	0		0	0		0	64.00
65.00 RESPIRATORY THERAPY	2,275,224	0	2,275,224	0		0	65.00
66.00 PHYSICAL THERAPY	232,714	0	232,714	0		0	66.00
67.00 OCCUPATIONAL THERAPY	127,435	0	127,435	0		0	67.00
68.00 SPEECH PATHOLOGY	127,779	0	127,779	0		0	68.00
69.00 ELECTROCARDIOLOGY	52,292		52,292	0		0	69.00
70.00 ELECTROENCEPHALOGRAPHY	7,120		7,120	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	1,722,066		1,722,066	0		0	73.00
74.00 RENAL DIALYSIS	243,338		243,338	0		0	74.00
75.00 ASC (NON-DISTINCT PART)	0		0	0		0	75.00
OTHER REIMBURSABLE COST CENTERS							
100.00 I&R SERVICES-NOT APPRVD PRGM	0		0			0	100.00
200.00 Subtotal (see instructions)	14,098,694	0	14,098,694	0		0	200.00
201.00 Less Observation Beds	0		0			0	201.00
202.00 Total (see instructions)	14,098,694	0	14,098,694	0		0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 152021

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

Worksheet C
Part I
Date/Time Prepared:
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Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	Cost
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	12,221,582		12,221,582			30.00
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	970,620	0	970,620	0.122203	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	1,071,627	1,515	1,073,142	0.474589	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	525,665	7,932	533,597	0.139019	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	3,706,722	619	3,707,341	0.110892	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.	219,428	0	219,428	0.387289	0.000000	63.00
64.00 INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
65.00 RESPIRATORY THERAPY	6,024,602	23,269	6,047,871	0.376202	0.000000	65.00
66.00 PHYSICAL THERAPY	692,145	0	692,145	0.336221	0.000000	66.00
67.00 OCCUPATIONAL THERAPY	662,526	0	662,526	0.192347	0.000000	67.00
68.00 SPEECH PATHOLOGY	290,416	103	290,519	0.439830	0.000000	68.00
69.00 ELECTROCARDIOLOGY	302,172	312	302,484	0.172875	0.000000	69.00
70.00 ELECTROENCEPHALOGRAPHY	10,371	0	10,371	0.686530	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	4,799,133	0	4,799,133	0.358829	0.000000	73.00
74.00 RENAL DIALYSIS	947,464	0	947,464	0.256831	0.000000	74.00
75.00 ASC (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	75.00
OTHER REIMBURSABLE COST CENTERS						
100.00 I&R SERVICES-NOT APPRVD PRGM	0	0	0			100.00
200.00 Subtotal (see instructions)	32,444,473	33,750	32,478,223			200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	32,444,473	33,750	32,478,223			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 152021

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

Worksheet C
Part I
Date/Time Prepared:
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Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
INPATIENT ROUTINE SERVICE COST CENTERS		11.00			
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
OTHER REIMBURSABLE COST CENTERS					
100.00	I&R SERVICES-NOT APPRVD PRGM				100.00
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: 152021		Period: From 07/01/2010 To 06/30/2011		Worksheet D Part I Date/Time Prepared: 12/29/2011 10:42 am	
Cost Center Description		Title XVIII		Hospital		PPS	
		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	969,737	0	969,737	7,599	127.61	30.00
200.00	Total (lines 30-199)	969,737		969,737	7,599		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 152021	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part I Date/Time Prepared: 12/29/2011 10:42 am
		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	5,382	686,797	30.00
200.00	Total (lines 30-199)	5,382	686,797	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 152021

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

Worksheet D
Part II
Date/Time Prepared:
12/29/2011 10:42 am

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	1,593	970,620	0.001641	631,514	1,036	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	5,430	1,073,142	0.005060	751,982	3,805	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	962	533,597	0.001803	435,373	785	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	19,862	3,707,341	0.005357	2,788,699	14,939	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.	924	219,428	0.004211	120,684	508	63.00
64.00	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	RESPIRATORY THERAPY	49,648	6,047,871	0.008209	4,873,854	40,009	65.00
66.00	PHYSICAL THERAPY	4,870	692,145	0.007036	496,708	3,495	66.00
67.00	OCCUPATIONAL THERAPY	2,838	662,526	0.004284	471,234	2,019	67.00
68.00	SPEECH PATHOLOGY	1,972	290,519	0.006788	189,331	1,285	68.00
69.00	ELECTROCARDIOLOGY	645	302,484	0.002132	183,081	390	69.00
70.00	ELECTROENCEPHALOGRAPHY	74	10,371	0.007135	7,729	55	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	70,143	4,799,133	0.014616	3,371,950	49,284	73.00
74.00	RENAL DIALYSIS	2,793	947,464	0.002948	557,459	1,643	74.00
75.00	ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
200.00	Total (lines 50-199)	161,754	20,256,641		14,879,598	119,253	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 152021

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

Worksheet D
Part IV
Date/Time Prepared:
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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: 152021

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

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Part IV
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Cost Center Description		Title XVIII			Hospital		PPS
		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	970,620	0.000000	0.000000	631,514	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	1,073,142	0.000000	0.000000	751,982	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	533,597	0.000000	0.000000	435,373	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	3,707,341	0.000000	0.000000	2,788,699	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	219,428	0.000000	0.000000	120,684	63.00
64.00	INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0	64.00
65.00	RESPIRATORY THERAPY	0	6,047,871	0.000000	0.000000	4,873,854	65.00
66.00	PHYSICAL THERAPY	0	692,145	0.000000	0.000000	496,708	66.00
67.00	OCCUPATIONAL THERAPY	0	662,526	0.000000	0.000000	471,234	67.00
68.00	SPEECH PATHOLOGY	0	290,519	0.000000	0.000000	189,331	68.00
69.00	ELECTROCARDIOLOGY	0	302,484	0.000000	0.000000	183,081	69.00
70.00	ELECTROENCEPHALOGRAPHY	0	10,371	0.000000	0.000000	7,729	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	4,799,133	0.000000	0.000000	3,371,950	73.00
74.00	RENAL DIALYSIS	0	947,464	0.000000	0.000000	557,459	74.00
75.00	ASC (NON-DISTINCT PART)	0	0	0.000000	0.000000	0	75.00
200.00	Total (lines 50-199)	0	20,256,641			14,879,598	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 152021

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

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Part IV
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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	1,515	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	7,932	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	619	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	23,269	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	103	0	0	0	0	68.00
69.00 ELECTROCARDIOLOGY	0	312	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	33,750	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 152021

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

Worksheet D
Part IV
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Cost Center Description		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

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 152021	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part V Date/Time Prepared: 12/29/2011 10:42 am
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Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			PPS	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	0.122203	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	0.474589	1,515	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	0.139019	7,932	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	0.110892	619	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.	0.387289	0	0	0	63.00
64.00	INTRAVENOUS THERAPY	0.000000	0	0	0	64.00
65.00	RESPIRATORY THERAPY	0.376202	23,269	0	0	65.00
66.00	PHYSICAL THERAPY	0.336221	0	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0.192347	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0.439830	103	0	0	68.00
69.00	ELECTROCARDIOLOGY	0.172875	312	0	0	69.00
70.00	ELECTROENCEPHALOGRAPHY	0.686530	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	0.358829	0	0	0	73.00
74.00	RENAL DIALYSIS	0.256831	0	0	0	74.00
75.00	ASC (NON-DISTINCT PART)	0.000000	0	0	0	75.00
200.00	Subtotal (see instructions)		33,750	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)		33,750	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 152021	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part V Date/Time Prepared: 12/29/2011 10:42 am
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Cost Center: Description	Costs			Hospital	PPS
	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	719	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	1,103	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	69	0	0		60.00
60.01 BLOOD LABORATORY	0	0	0		60.01
61.00 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0		61.00
62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0		62.00
63.00 BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
64.00 INTRAVENOUS THERAPY	0	0	0		64.00
65.00 RESPIRATORY THERAPY	8,754	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	45	0	0		68.00
69.00 ELECTROCARDIOLOGY	54	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	0	0	0		73.00
74.00 RENAL DIALYSIS	0	0	0		74.00
75.00 ASC (NON-DISTINCT PART)	0	0	0		75.00
200.00 Subtotal (see instructions)	10,744	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)	10,744	0	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 152021		Period: From 07/01/2010 To 06/30/2011		Worksheet D Part I Date/Time Prepared: 12/29/2011 10:42 am		
Cost Center Description			Capital Related Cost (from wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	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		969,737	0	969,737	7,599	127.61	30.00
200.00	Total (lines 30-199)		969,737		969,737	7,599		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 152021		Period: From 07/01/2010 To 06/30/2011	Worksheet D Part I Date/Time Prepared: 12/29/2011 10:42 am
		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	571	72,865		30.00
200.00	Total (lines 30-199)	571	72,865		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 152021	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part II Date/Time Prepared: 12/29/2011 10:42 am
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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	1,593	970,620	0.001641	98,371	161	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	5,430	1,073,142	0.005060	112,591	570	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	962	533,597	0.001803	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	19,862	3,707,341	0.005357	265,645	1,423	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.	924	219,428	0.004211	0	0	63.00
64.00 INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00 RESPIRATORY THERAPY	49,648	6,047,871	0.008209	461,007	3,784	65.00
66.00 PHYSICAL THERAPY	4,870	692,145	0.007036	34,315	241	66.00
67.00 OCCUPATIONAL THERAPY	2,838	662,526	0.004284	38,056	163	67.00
68.00 SPEECH PATHOLOGY	1,972	290,519	0.006788	23,760	161	68.00
69.00 ELECTROCARDIOLOGY	645	302,484	0.002132	17,479	37	69.00
70.00 ELECTROENCEPHALOGRAPHY	74	10,371	0.007135	1,629	12	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	70,143	4,799,133	0.014616	387,699	5,667	73.00
74.00 RENAL DIALYSIS	2,793	947,464	0.002948	28,943	85	74.00
75.00 ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
200.00 Total (lines 50-199)	161,754	20,256,641		1,469,495	12,304	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 152021	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part III Date/Time Prepared: 12/29/2011 10:42 am
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Cost Center Description	Title XIX				Hospital	Cost
	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 5, minus col. 4)	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	0	0	0	0	0	30.00
200.00 Total (lines 30-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 152021	Period: From 07/01/2010 To 06/30/2011	Worksheet D Part III Date/Time Prepared: 12/29/2011 10:42 am
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Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Hospital Cost		
				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	7,599	0.00	571	0	0	30.00
200.00 Total (lines 30-199)	7,599		571	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 152021		Period: From 07/01/2010 To 06/30/2011	Worksheet D Part III Date/Time Prepared: 12/29/2011 10:42 am
		Title XIX		Hospital	Cost
Cost Center Description	PSA Adj. Allied Health Cost	PSA Adj. All Other Medical Education Cost			
	12.00	13.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS	0	0		30.00
200.00	Total (lines 30-199)	0	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 152021

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

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 152021

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

Worksheet D
Part IV
Date/Time Prepared:
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Cost Center Description	Title XIX			Hospital		Cost
	Total	Total Charges	Ratio of Cost	Outpatient	Inpatient	
	Outpatient Cost (sum of col. 2, 3 and 4)	(from Wkst. C, Part I, col. 8)	to Charges (col. 5 ÷ col. 7)	Ratio of Cost to Charges (col. 6 ÷ col. 7)	Program Charges	
	6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS						
50.00	OPERATING ROOM	0	970,620	0.000000	0.000000	98,371 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	1,073,142	0.000000	0.000000	112,591 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	533,597	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	3,707,341	0.000000	0.000000	265,645 60.00
60.01	BLOOD LABORATORY	0	0	0.000000	0.000000	0 60.01
61.00	PBP CLINICAL LAB SERVICES-PRGM ONLY					
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.000000	0.000000	0 62.00
63.00	BLOOD STORING, PROCESSING & TRANS.	0	219,428	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	6,047,871	0.000000	0.000000	461,007 65.00
66.00	PHYSICAL THERAPY	0	692,145	0.000000	0.000000	34,315 66.00
67.00	OCCUPATIONAL THERAPY	0	662,526	0.000000	0.000000	38,056 67.00
68.00	SPEECH PATHOLOGY	0	290,519	0.000000	0.000000	23,760 68.00
69.00	ELECTROCARDIOLOGY	0	302,484	0.000000	0.000000	17,479 69.00
70.00	ELECTROENCEPHALOGRAPHY	0	10,371	0.000000	0.000000	1,629 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	4,799,133	0.000000	0.000000	387,699 73.00
74.00	RENAL DIALYSIS	0	947,464	0.000000	0.000000	28,943 74.00
75.00	ASC (NON-DISTINCT PART)	0	0	0.000000	0.000000	0 75.00
200.00	Total (lines 50-199)	0	20,256,641			1,469,495 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 152021

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

Worksheet D
Part IV
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Cost Center Description	Title XIX			Hospital		Cost
	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
	11.00	12.00	13.00	21.00	22.00	
ANCILLARY SERVICE COST CENTERS						
50.00 OPERATING ROOM	0	0	0	0	0	50.00
51.00 RECOVERY ROOM	0	0	0	0	0	51.00
52.00 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00 RADIOISOTOPE	0	0	0	0	0	56.00
57.00 CT SCAN	0	0	0	0	0	57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 LABORATORY	0	0	0	0	0	60.00
60.01 BLOOD LABORATORY	0	0	0	0	0	60.01
61.00 PBP CLINICAL LAB 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: 152021

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

Worksheet D
Part IV
Date/Time Prepared:
12/29/2011 10:42 am

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: 152021	Period: From 07/01/2010 To 06/30/2011	Worksheet D-1 Date/Time Prepared: 12/29/2011 10:42 am
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)		7,599	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		7,599	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)		7,599	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)		5,382	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)		8,112,534	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)		8,112,534	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		12,221,582	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)		0.663788	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)		8,112,534	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)		1,067.58	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		5,745,716	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)		5,745,716	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 152021	Period: From 07/01/2010 To 06/30/2011	Worksheet D-1 Date/Time Prepared: 12/29/2011 10:42 am
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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)	
	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)					4,415,117	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					10,160,833	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)					686,797	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from wkst. D, sum of Parts II and IV)					119,253	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					806,050	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					9,354,783	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: 152021

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

Worksheet D-1

Date/Time Prepared:
12/29/2011 10:42 am

Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Hospital		Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)
				Total Observation Bed Cost (from line 89)	PPS	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	969,737	8,112,534	0.119536	0	0	90.00
91.00 Nursing School cost	0	8,112,534	0.000000	0	0	91.00
92.00 Allied health cost	0	8,112,534	0.000000	0	0	92.00
93.00 All other Medical Education	0	8,112,534	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 152021	Period: From 07/01/2010 To 06/30/2011	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 12/29/2011 10:42 am
Cost Center Description				Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			7,599 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			7,599 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)			7,599 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)			571 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)			8,112,534 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)			8,112,534 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)			12,221,582 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)			0.663788 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)			8,112,534 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)			1,067.58 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			609,588 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)			609,588 41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 152021

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

Worksheet D-1

Date/Time Prepared:
12/29/2011 10:42 am

Cost Center Description	Title XIX			Hospital	Cost	
	Total	Total	Average Per	Program Days	Program Cost	
	Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)		(col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT						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)					448,343	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,057,931	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: 152021	Period: From 07/01/2010 To 06/30/2011	Worksheet D-1 Date/Time Prepared: 12/29/2011 10:42 am
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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	0	90.00
91.00 Nursing School cost	0	0	0.000000	0	0	91.00
92.00 Allied health cost	0	0	0.000000	0	0	92.00
93.00 All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 152021	Period: From 07/01/2010 To 06/30/2011	Worksheet D-3 Date/Time Prepared: 12/29/2011 10:42 am
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Cost Center Description		Ratio of Cost To Charges	Hospital Inpatient Program Charges	PPS Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS		8,413,846		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM	0.122203	631,514	77,173	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	0.474589	751,982	356,882	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	0.139019	435,373	60,525	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	0.110892	2,788,699	309,244	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.	0.387289	120,684	46,740	63.00
64.00	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	RESPIRATORY THERAPY	0.376202	4,873,854	1,833,554	65.00
66.00	PHYSICAL THERAPY	0.336221	496,708	167,004	66.00
67.00	OCCUPATIONAL THERAPY	0.192347	471,234	90,640	67.00
68.00	SPEECH PATHOLOGY	0.439830	189,331	83,273	68.00
69.00	ELECTROCARDIOLOGY	0.172875	183,081	31,650	69.00
70.00	ELECTROENCEPHALOGRAPHY	0.686530	7,729	5,306	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	0.358829	3,371,950	1,209,953	73.00
74.00	RENAL DIALYSIS	0.256831	557,459	143,173	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)		14,879,598	4,415,117	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)		14,879,598		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 152021

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

Worksheet D-3

Date/Time Prepared:
12/29/2011 10:42 am

Cost Center Description	Ratio of Cost To Charges	Hospital Cost		
		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		851,241		30.00
ANCILLARY SERVICE COST CENTERS				
50.00 OPERATING ROOM	0.122203	98,371	12,021	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	0.474589	112,591	53,434	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	0.139019	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	0.110892	265,645	29,458	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.	0.387289	0	0	63.00
64.00 INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00 RESPIRATORY THERAPY	0.376202	461,007	173,432	65.00
66.00 PHYSICAL THERAPY	0.336221	34,315	11,537	66.00
67.00 OCCUPATIONAL THERAPY	0.192347	38,056	7,320	67.00
68.00 SPEECH PATHOLOGY	0.439830	23,760	10,450	68.00
69.00 ELECTROCARDIOLOGY	0.172875	17,479	3,022	69.00
70.00 ELECTROENCEPHALOGRAPHY	0.686530	1,629	1,118	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	0.358829	387,699	139,118	73.00
74.00 RENAL DIALYSIS	0.256831	28,943	7,433	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)		1,469,495	448,343	200.00
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00 Net Charges (line 200 minus line 201)		1,469,495		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 152021	Period: From 07/01/2010 To 06/30/2011	Worksheet E Part B Date/Time Prepared: 12/29/2011 10:42 am
		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 OPPS (see instructions)			10,744 2.00
3.00	PPS payments			1,345 3.00
4.00	Outlier payment (see instructions)			2,715 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)			4,060 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)			275 26.00
27.00	Subtotal [(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23] (for CAH, see instructions)			3,785 27.00
28.00	Direct graduate medical education payments (from worksheet E-4, line 50)			0 28.00
29.00	ESRD direct medical education costs (from worksheet E-4, line 36)			0 29.00
30.00	Subtotal (sum of lines 27 through 29)			3,785 30.00
31.00	Primary payer payments			0 31.00
32.00	Subtotal (line 30 minus line 31)			3,785 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)			3,785 37.00
38.00	MSP-LCC reconciliation amount from PS&R			0 38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0 39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)			3,785 40.00
41.00	Interim payments			3,785 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: 152021	Period: From 07/01/2010 To 06/30/2011	Worksheet E Part B Date/Time Prepared: 12/29/2011 10:42 am
Title XVIII		Hospital	PPS
WORKSHEET OVERRIDE VALUES			Overrides
			1.00
112.00	override of Ancillary service charges (line 12)	0	112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 152021

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

Worksheet E-1
Part I
Date/Time Prepared:
12/29/2011 10:42 am

		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		8,247,124		3,785	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)		8,247,124		3,785	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		140,792		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		8,387,916		3,785	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: 152021	Period: From 07/01/2010 To 06/30/2011	Worksheet E-3 Part IV Date/Time Prepared: 12/29/2011 10:42 am
		Title XVIII	Hospital	PPS
		1.00		
PART IV - MEDICARE PART A SERVICES - LTCH PPS				
1.00	Net Federal PPS Payments (see instructions)			7,175,351 1.00
2.00	Outlier Payments			1,620,657 2.00
3.00	Total PPS Payments (sum of lines 1 and 2)			8,796,008 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)			8,796,008 7.00
8.00	Primary payer payments			0 8.00
9.00	Subtotal (line 7 less line 8).			8,796,008 9.00
10.00	Deductibles			15,560 10.00
11.00	Subtotal (line 9 minus line 10)			8,780,448 11.00
12.00	Coinsurance			533,324 12.00
13.00	Subtotal (line 11 minus line 12)			8,247,124 13.00
14.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			201,132 14.00
15.00	Adjusted reimbursable bad debts (see instructions)			140,792 15.00
16.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			195,719 16.00
17.00	Subtotal (sum of lines 13 and 15)			8,387,916 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)			8,387,916 22.00
23.00	Interim payments			8,247,124 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)			140,792 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: 152021	Period: From 07/01/2010 To 06/30/2011	Worksheet E-3 Part VII Date/Time Prepared: 12/29/2011 10:42 am
		Title XIX	Hospital	Cost
				1.00
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		1,057,931	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)		1,057,931	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)		1,057,931	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges		851,241	8.00
9.00	Ancillary service charges		1,469,495	9.00
10.00	Organ acquisition charges, net of revenue		0	10.00
11.00	Incentive from target amount computation		0	11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		2,320,736	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)		2,320,736	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 7) (see instructions)		1,262,805	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)		1,057,931	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)		1,057,931	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)		1,057,931	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	37.00
38.00	Subtotal (line 36 ± line 37)		1,057,931	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)		1,057,931	40.00
41.00	Interim payments		1,057,931	41.00
42.00	Balance due provider/program (line 40 minus 41)		0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2		0	43.00

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

Provider CCN: 152021

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

Worksheet G

Date/Time Prepared:
12/29/2011 10:42 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	489,985	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	3,336,511	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-1,214,786	0	0	0	6.00
7.00	Inventory	135,458	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	7,788,601	0	0	0	9.00
10.00	Due from other funds	140,792	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	10,676,561	0	0	0	11.00
FIXED ASSETS						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	0	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	845,098	0	0	0	17.00
18.00	Accumulated depreciation	-644,000	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	1,068,622	0	0	0	23.00
24.00	Accumulated depreciation	-814,334	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)	455,386	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	13,383	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	13,383	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	11,145,330	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	296,190	0	0	0	37.00
38.00	Salaries, wages, and fees payable	617,052	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	1,196,175	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2,109,417	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	3,681	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	3,681	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	2,113,098	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	9,032,232				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)	9,032,232	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	11,145,330	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 152021

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

Worksheet G-1

Date/Time Prepared:
12/29/2011 10:42 am

	General Fund		Special Purpose Fund		
	1.00	2.00	3.00	4.00	
1.00		6,640,511		0	1.00
2.00		1,791,378			2.00
3.00		8,431,889		0	3.00
4.00	600,343			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		600,343		0	10.00
11.00		9,032,232		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		9,032,232		0	19.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 152021

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

Worksheet G-1

Date/Time Prepared:
12/29/2011 10:42 am

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 152021

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

Worksheet G-2 Parts

Date/Time Prepared:
12/29/2011 10:42 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	12,221,582		12,221,582	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)	12,221,582		12,221,582	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)	12,221,582		12,221,582	17.00
18.00	Ancillary services	20,256,641	0	20,256,641	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)	32,478,223	0	32,478,223	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per wkst. A, column 3, line 200)		13,196,736		29.00
30.00	BAD DEBTS	99,499			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)		99,499		36.00
37.00		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)		13,296,235		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 152021	Period: From 07/01/2010 To 06/30/2011	Worksheet G-3 Date/Time Prepared: 12/29/2011 10:42 am
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		1.00	
1.00	Total patient revenues (from wkst. G-2, Part I, column 3, line 28)	32,478,223	1.00
2.00	Less contractual allowances and discounts on patients' accounts	18,494,643	2.00
3.00	Net patient revenues (line 1 minus line 2)	13,983,580	3.00
4.00	Less total operating expenses (from wkst. G-2, Part II, line 43)	13,296,235	4.00
5.00	Net income from service to patients (line 3 minus line 4)	687,345	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	22,683	6.00
7.00	Income from investments	1,076,489	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	437	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	1,782	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MAINTENANCE REV	859	24.00
24.01	FINANCIAL SVCS REV	1,783	24.01
25.00	Total other income (sum of lines 6-24)	1,104,033	25.00
26.00	Total (line 5 plus line 25)	1,791,378	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,791,378	29.00