
ST. VINCENT FRANKFORT HOSPITAL
PROVIDER NO. 15-1316, 15-Z316, AND AIM NO. 100268560A
HOSPITAL STATEMENTS OF REIMBURSABLE COSTS
(MEDICARE AND MEDICAID PROGRAMS)
JUNE 30, 2013

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 151316	Period: From 07/01/2012 To 06/30/2013	Worksheet 5 Parts I-III Date/Time Prepared: 11/26/2013 12:58 pm
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PART I - COST REPORT STATUS

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

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

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

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

Date: 11/26/2013 Time: 12:58 pm

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 certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST. VINCENT FRANKFORT HOSPITAL (151316) for the cost reporting period beginning 07/01/2012 and ending 06/30/2013 and to the best of my knowledge and belief, this report and statement are true, correct, complete and 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, and that the services identified in this cost report were provided in compliance with such laws and regulations.

Encryption Information

ECR: Date: 11/26/2013 Time: 12:58 pm
 mCCWnCJanY90Bz1zUgLy7ZQIaFiKm0
 fQjGA0YXLMUXFXeL1x99QcBLu0oXPN
 pd4g0bP3ut0g0JNf
 PI: Date: 11/26/2013 Time: 12:58 pm
 :Xoho1hc4w6GhHJI61jAFA.1pdy4b0
 1ezT10emxw0Sw6b91cF2ymwRxc63oh
 u0UJ0LpUKZ0396P1

(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	221,572	-206,494	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
5.00 Swing bed - SNF	0	66,716	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
200.00 Total	0	288,288	-206,494	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.

		1.00	2.00	3.00	4.00					
		Hospital and Hospital Health Care Complex Address:								
1.00	Street: 1300 SOUTH JACKSON STREET	PO Box:		Zip Code: 46041		County: CLINTON			1.00	
2.00	City: FRANKFORT	State: IN							2.00	
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
							V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
		Hospital and Hospital-Based Component Identification:								
3.00	Hospital	ST. VINCENT FRANKFORT HOSPITAL	151316	99915	1	01/21/2003	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	ST. VINCENT FRANKFORT HOSPITAL	152316	99915		01/21/2003	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00
						From:	To:			
						1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)					07/01/2012	06/30/2013			20.00
21.00	Type of Control (see instructions)					2				21.00
		Inpatient PPS Information								
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	N			22.00
23.00	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 unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days			
		1.00	2.00	3.00	4.00	5.00	6.00			
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0		24.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.	0	0	0	0	0	0		25.00	
						Urban/Rural S	Date of Geogr			
						1.00	2.00			
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					2			26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					2			27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0			35.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151316	Period: From 07/01/2012 To 06/30/2013	Worksheet S-2 Part I Date/Time Prepared: 11/26/2013 9:24 am		
		Beginning: 1.00	Ending: 2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0				37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.					38.00
		Y/N 1.00	Y/N 2.00			
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N			39.00
		V 1.00	XVIII 2.00	XIX 3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N		45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete worksheet L, Part III and L-1, Parts I through III.	N	N	N		46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N		47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N				56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete worksheet E-4. If column 2 is "N", complete worksheet D, Part III & IV and D-2, Part II, if applicable.					57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete worksheet D-5.	N				58.00
59.00	Are costs claimed on line 100 of worksheet A? If yes, complete worksheet D-2, Part I.	N				59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N				60.00
		Y/N 1.00	IME 2.00	Direct GME 3.00	IME 4.00	Direct GME 5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00		61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN and general surgery) added as a result of section 5503. (see instructions)		0.00	0.00		61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00		61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00		61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00		61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00		61.06
		Program Name 1.00	Program Code 2.00	Unweighted IME FTE Count 3.00	Unweighted Direct GME FTE Count 4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.10

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 151316

Period:
From 07/01/2012
To 06/30/2013

Worksheet S-2
Part I
Date/Time Prepared:
11/26/2013 9:24 am

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count		
		1.00	2.00	3.00	4.00		
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.20	
		1.00					
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 in column 1. 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, if line 63 is yes, or your facility trained residents in the base year period, 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, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
		1.00	2.00	3.00			
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010 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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151316	Period: From 07/01/2012 To 06/30/2013	Worksheet S-2 Part I Date/Time Prepared: 11/26/2013 9:24 am			
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
67.00	Enter in column 1 the program name associated with each of your primary care programs in which you trained residents. 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		70.00	
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or 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		75.00	
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or 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 and "N" for no.			N		80.00	
TEFRA Providers							
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N		85.00	
86.00	Did this facility establish a new other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.					86.00	
			V	XIX			
			1.00	2.00			
Title V and XIX Services							
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	Y	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.				N	92.00	
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.				0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.			N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.				0.00	97.00	
Rural Providers							
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?			Y		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			N		106.00	

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		V	XIX			
		1.00	2.00			
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N				107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N				108.00
		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	Y	Y	N	N	109.00
		1.00	2.00	3.00		
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. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.	N			0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y				117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2				118.00
		Premiums	Losses	Insurance		
		1.00	2.00	3.00		
118.01	List amounts of malpractice premiums and paid losses:	1	0	0		
		1.00	2.00			
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N				118.02
119.00	DO NOT USE THIS LINE					119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) 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 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.	N		N		120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y				121.00
Transplant Center Information						
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N				125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00
All Providers						
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y				140.00

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151316	Period: From 07/01/2012 To 06/30/2013	Worksheet S-2 Part I Date/Time Prepared: 11/26/2013 9:24 am			
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: WPS		Contractor's Number: 08001		141.00	
142.00	Street: 10330 N. MERIDIAN ST. SUITE 420	PO Box:				142.00	
143.00	City: INDIANAPOLIS	State: IN		Zip Code: 46290		143.00	
						1.00	
144.00	Are provider based physicians' costs included in worksheet A?					Y	144.00
145.00	If costs for renal services are claimed on worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.					N	145.00
						1.00	
						2.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.					N	146.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.					N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.					N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.					N	149.00
		Part A	Part B	Title V	Title XIX		
		1.00	2.00	3.00	4.00		
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	N	N		155.00
156.00	Subprovider - IPF	N	N	N	N		156.00
157.00	Subprovider - IRF	N	N	N	N		157.00
158.00	SUBPROVIDER						158.00
159.00	SNF	N	N	N	N		159.00
160.00	HOME HEALTH AGENCY	N	N	N	N		160.00
161.00	CMHC		N	N	N		161.00
						1.00	
165.00	Multicampus Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.					N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus
		0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00
						1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.					N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						0.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.00
						Beginning	Ending
						1.00	2.00
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)						

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 151316	Period: From 07/01/2012 To 06/30/2013	Worksheet S-2 Part II Date/Time Prepared: 11/26/2013 9:24 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	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.		N		5.00
			Y/N	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?		N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.		N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.		N		8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.		N		9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.		N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on worksheet A? If yes, see instructions.		N		11.00
				Y/N	
				1.00	
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Description	Part A		Part B
		0	Y/N	Date	Y/N
			1.00	2.00	3.00
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	10/02/2013	Y
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		N
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		N
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		N
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N

	Description	Part A		Part B	
		Y/N	Date	Y/N	
	0	1.00	2.00	3.00	
21.00	was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N	25.00
26.00	were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
Interest Expense					
28.00	were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			N	33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N	35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	were home office costs claimed on the cost report?			Y	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			Y	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N	40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	JILL		HILL	41.00
42.00	Enter the employer/company name of the cost report preparer.	ST VINCENT HEALTH			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-583-3232		JILL.HILL@STVINCENT.ORG	43.00

		Part B		
		Date		
		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)	10/02/2013		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)			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.			19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.			21.00
			3.00	
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR OF REIMBURSEMENT		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

Provider CCN: 151316

Period:
From 07/01/2012
To 06/30/2013

Worksheet S-2
Part IX
Date/Time Prepared:
11/26/2013 9:24 am

		Title V 1.00	Title XIX 2.00	
TITLES V AND/OR XIX FOLLOWING MEDICARE				
1.00	Do Title V or XIX follow Medicare (Title XVIII) for the Interns and Residence post stepdown adjustments on w/S B, Part I, column 25? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	1.00
2.00	Do Title V or XIX follow Medicare (Title XVIII) for the reporting of charges on w/S C, Part I (e.g. net of Physician's component)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	2.00
3.00	Do Title V or XIX follow Medicare (Title XVIII) for the calculation of Observation Bed Cost on w/S D-1, Part IV, line 89? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	3.00
		Inpatient 1.00	Outpatient 2.00	
CRITICAL ACCESS HOSPITALS				
4.00	Does Title V follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.	N	N	4.00
5.00	Does Title XIX follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.	N	N	5.00
		Title V 1.00	Title XIX 2.00	
RCE DISALLOWANCE				
6.00	Do Title V or XIX follow Medicare and add back the RCE Disallowance on w/S C, Part I column 4? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	6.00
PASS THROUGH COST				
7.00	Do Title V or XIX follow Medicare when cost reimbursed (payment system is "0") for worksheets D, parts I through IV? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	7.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151316

Period:
From 07/01/2012
To 06/30/2013

Worksheet S-3
Part I
Date/Time Prepared:
11/26/2013 9:24 am

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	Title V
	Line Number				Visits / Trips	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	57,120.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	57,120.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		25	9,125	57,120.00	0	14.00
15.00 CAH visits					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
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		25				27.00
28.00 Observation Bed Days					0	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

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,328	48	2,380			1.00
2.00 HMO and other (see instructions)	158	369				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	822	0	844			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	63			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	2,150	48	3,287			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		368	475			13.00
14.00 Total (see instructions)	2,150	416	3,762	0.00	143.10	14.00
15.00 CAH visits	12,706	2,317	38,240			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
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
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	143.10	27.00
28.00 Observation Bed Days		0	551			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			44			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)		53	67			32.00
33.00 LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151316

Period:
From 07/01/2012
To 06/30/2013

Worksheet S-3
Part I
Date/Time Prepared:
11/26/2013 9:24 am

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)			0	342	198	858	1.00
2.00 HMO and other (see instructions)				36			2.00
3.00 HMO IPF Subprovider							3.00
4.00 HMO IRF Subprovider							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	0		342	198	858	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
24.10 HOSPICE (non-distinct part)							24.10
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						27.00
28.00 Observation Bed Days							28.00
29.00 Ambulance Trips							29.00
30.00 Employee discount days (see instruction)							30.00
31.00 Employee discount days - IRF							31.00
32.00 Labor & delivery days (see instructions)							32.00
33.00 LTCH non-covered days							33.00

				1.00	
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.314816	1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid			0	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?			Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?			N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid			1,117,577	5.00
6.00	Medicaid charges			11,657,844	6.00
7.00	Medicaid cost (line 1 times line 6)			3,670,076	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)			2,552,499	8.00
State Children's Health Insurance Program (SCHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone SCHIP			0	9.00
10.00	Stand-alone SCHIP charges			0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)			0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)			0	12.00
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)			0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)			0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)			0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)			0	16.00
Uncompensated care (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care			0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations			9,459	18.00
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)			2,552,499	19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	5,293,683	101,506	5,395,189	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	1,666,536	31,956	1,698,492	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,666,536	31,956	1,698,492	23.00
				1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit			0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)			312,254	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)			468,519	27.00
28.00	Non-Medicare and Non-Reimbursable Medicare bad debt expense (line 26 minus line 27)			-156,265	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)			-49,195	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)			1,649,297	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			4,201,796	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151316

Period:
From 07/01/2012
To 06/30/2013

Worksheet A

Date/Time Prepared:
11/26/2013 9:24 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (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	00100		1,262,841	1,262,841	0	1,262,841	1.00	
2.00	00200		778,546	778,546	-2,247	776,299	2.00	
3.00	00300		0	0	0	0	3.00	
4.00	00400	299,895	2,256,951	2,556,846	-7	2,556,839	4.00	
5.00	00500	1,825,052	2,976,047	4,801,099	1,808	4,802,907	5.00	
7.00	00700	230,699	1,262,712	1,493,411	-18	1,493,393	7.00	
8.00	00800	0	108,776	108,776	0	108,776	8.00	
9.00	00900	0	518,602	518,602	-1	518,601	9.00	
10.00	01000	0	579,165	579,165	-461,407	117,758	10.00	
11.00	01100	0	0	0	461,305	461,305	11.00	
12.00	01200	0	0	0	0	0	12.00	
13.00	01300	849,319	37,310	886,629	-1	886,628	13.00	
14.00	01400	149,355	47,382	196,737	-3,123	193,614	14.00	
15.00	01500	267,201	580,265	847,466	-1,082	846,384	15.00	
16.00	01600	74,075	90,595	164,670	-8	164,662	16.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	1,805,830	180,059	1,985,889	-493,004	1,492,885	30.00	
43.00	04300	0	0	0	163,424	163,424	43.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	425,214	961,842	1,387,056	-68,346	1,318,710	50.00	
52.00	05200	0	0	0	307,524	307,524	52.00	
54.00	05400	634,010	316,471	950,481	-4,753	945,728	54.00	
60.00	06000	583,238	876,441	1,459,679	-3,937	1,455,742	60.00	
65.00	06500	159,902	132,258	292,160	-1,827	290,333	65.00	
66.00	06600	1,432	900,784	902,216	-206,765	695,451	66.00	
67.00	06700	0	0	0	198,487	198,487	67.00	
68.00	06800	64,816	941	65,757	0	65,757	68.00	
71.00	07100	0	39,181	39,181	135,451	174,632	71.00	
72.00	07200	0	107,337	107,337	0	107,337	72.00	
73.00	07300	0	0	0	0	0	73.00	
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	951,754	796,166	1,747,920	-21,249	1,726,671	91.00	
92.00	09200						92.00	
SPECIAL PURPOSE COST CENTERS								
118.00	SUBTOTALS (SUM OF LINES 1-117)		8,321,792	14,810,672	23,132,464	224	23,132,688	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	0	0	0	0	0	190.00	
194.00	07950	82,251	309,826	392,077	-224	391,853	194.00	
194.01	07951	0	1,431	1,431	0	1,431	194.01	
194.02	07952	0	0	0	0	0	194.02	
200.00	TOTAL (SUM OF LINES 118-199)		8,404,043	15,121,929	23,525,972	0	23,525,972	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151316

Period:
From 07/01/2012
To 06/30/2013

Worksheet A
Date/Time Prepared:
11/26/2013 9:24 am

Cost Center Description		Adjustments (See A-8) 6.00	Net Expenses For Allocation 7.00		
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-6,364	1,256,477	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-8,765	767,534	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	507,136	3,063,975	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-233,149	4,569,758	5.00
7.00	00700	OPERATION OF PLANT	6,117	1,499,510	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	108,776	8.00
9.00	00900	HOUSEKEEPING	0	518,601	9.00
10.00	01000	DIETARY	0	117,758	10.00
11.00	01100	CAFETERIA	-106,031	355,274	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	-1,810	884,818	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-10,481	183,133	14.00
15.00	01500	PHARMACY	-10,814	835,570	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	164,662	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-8,535	1,484,350	30.00
43.00	04300	NURSERY	0	163,424	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-594,669	724,041	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	307,524	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-146,179	799,549	54.00
60.00	06000	LABORATORY	0	1,455,742	60.00
65.00	06500	RESPIRATORY THERAPY	-676	289,657	65.00
66.00	06600	PHYSICAL THERAPY	-19,371	676,080	66.00
67.00	06700	OCCUPATIONAL THERAPY	-667	197,820	67.00
68.00	06800	SPEECH PATHOLOGY	0	65,757	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	174,632	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	107,337	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	-70,115	1,656,556	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	-704,373	22,428,315	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
194.00	07950	OTHER NONREIMBURSABLE - CLINIC	233,713	625,566	194.00
194.01	07951	OTHER NONREIMBURSABLE - FOUNDATION	0	1,431	194.01
194.02	07952	OTHER NONREIMBURSABLE - MARKETING	0	0	194.02
200.00		TOTAL (SUM OF LINES 118-199)	-470,660	23,055,312	200.00

COST CENTERS USED IN COST REPORT		Provider CCN: 151316	Period: From 07/01/2012 To 06/30/2013	Worksheet Non-CMS W Date/Time Prepared: 11/26/2013 9:24 am
Cost Center Description		CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	00100		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	00200		2.00
3.00	OTHER CAP REL COSTS	00300		3.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	00400		4.00
5.00	ADMINISTRATIVE & GENERAL	00500		5.00
7.00	OPERATION OF PLANT	00700		7.00
8.00	LAUNDRY & LINEN SERVICE	00800		8.00
9.00	HOUSEKEEPING	00900		9.00
10.00	DIETARY	01000		10.00
11.00	CAFETERIA	01100		11.00
12.00	MAINTENANCE OF PERSONNEL	01200		12.00
13.00	NURSING ADMINISTRATION	01300		13.00
14.00	CENTRAL SERVICES & SUPPLY	01400		14.00
15.00	PHARMACY	01500		15.00
16.00	MEDICAL RECORDS & LIBRARY	01600		16.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	03000		30.00
43.00	NURSERY	04300		43.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	05000		50.00
52.00	DELIVERY ROOM & LABOR ROOM	05200		52.00
54.00	RADIOLOGY-DIAGNOSTIC	05400		54.00
60.00	LABORATORY	06000		60.00
65.00	RESPIRATORY THERAPY	06500		65.00
66.00	PHYSICAL THERAPY	06600		66.00
67.00	OCCUPATIONAL THERAPY	06700		67.00
68.00	SPEECH PATHOLOGY	06800		68.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	07100		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	07200		72.00
73.00	DRUGS CHARGED TO PATIENTS	07300		73.00
OUTPATIENT SERVICE COST CENTERS				
91.00	EMERGENCY	09100		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	09200		92.00
SPECIAL PURPOSE COST CENTERS				
118.00	SUBTOTALS (SUM OF LINES 1-117)			118.00
NONREIMBURSABLE COST CENTERS				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	19000		190.00
194.00	OTHER NONREIMBURSABLE - CLINIC	07950		194.00
194.01	OTHER NONREIMBURSABLE - FOUNDATION	07951		194.01
194.02	OTHER NONREIMBURSABLE - MARKETING	07952		194.02
200.00	TOTAL (SUM OF LINES 118-199)			200.00

		Increases				
Cost Center		Line #	Salary	Other		
2.00		3.00	4.00	5.00		
A - CAFETERIA RECLASS						
1.00	CAFETERIA	11.00	0	461,305		1.00
	TOTALS		0	461,305		
B - NURSEY AND L&D RECLASS						
1.00	NURSERY	43.00	144,586	18,838		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	272,076	35,448		2.00
	TOTALS		416,662	54,286		
C - INTEREST						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	2,247		1.00
	TOTALS		0	2,247		
D - MEDICAL SUPPLIES						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	135,451		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
	TOTALS		0	135,451		
E - OT EXPENSE						
1.00	OCCUPATIONAL THERAPY	67.00	315	198,172		1.00
	TOTALS		315	198,172		
500.00	Grand Total: Increases		416,977	851,461		500.00

		Decreases					
	Cost Center	Line #	Salary	Other	wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - CAFETERIA RECLASS							
1.00	DIETARY	10.00	0	461,305	0		1.00
	TOTALS		0	461,305			
B - NURSEY AND L&D RECLASS							
1.00	ADULTS & PEDIATRICS	30.00	416,662	54,286	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		416,662	54,286			
C - INTEREST							
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	2,247	9		1.00
	TOTALS		0	2,247			
D - MEDICAL SUPPLIES							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	7	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	439	0		2.00
3.00	OPERATION OF PLANT	7.00	0	18	0		3.00
4.00	HOUSEKEEPING	9.00	0	1	0		4.00
5.00	DIETARY	10.00	0	102	0		5.00
6.00	NURSING ADMINISTRATION	13.00	0	1	0		6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	3,123	0		7.00
8.00	PHARMACY	15.00	0	1,082	0		8.00
9.00	MEDICAL RECORDS & LIBRARY	16.00	0	8	0		9.00
10.00	ADULTS & PEDIATRICS	30.00	0	22,056	0		10.00
11.00	OPERATING ROOM	50.00	0	68,346	0		11.00
12.00	RADIOLOGY-DIAGNOSTIC	54.00	0	4,753	0		12.00
13.00	LABORATORY	60.00	0	3,937	0		13.00
14.00	RESPIRATORY THERAPY	65.00	0	1,827	0		14.00
15.00	PHYSICAL THERAPY	66.00	0	8,278	0		15.00
16.00	EMERGENCY	91.00	0	21,249	0		16.00
17.00	OTHER NONREIMBURSABLE - CLINIC	194.00	0	224	0		17.00
	TOTALS		0	135,451			
E - OT EXPENSE							
1.00	PHYSICAL THERAPY	66.00	315	198,172	0		1.00
	TOTALS		315	198,172			
500.00	Grand Total: Decreases		416,977	851,461			500.00

RECLASSIFICATIONS

Provider CCN: 151316

Period:
From 07/01/2012
To 06/30/2013

Worksheet A-6
Non-CMS Worksheet
Date/Time Prepared:
11/26/2013 9:24 am

Increases			Decreases			
Cost Center	Line #	Salary	Cost Center	Line #	Salary	
2.00	3.00	4.00	6.00	7.00	8.00	
A - CAFETERIA RECLASS						
1.00	CAFETERIA	11.00	DIETARY	10.00	0	1.00
	TOTALS	0	TOTALS		0	
B - NURSEY AND L&D RECLASS						
1.00	NURSERY	43.00	ADULTS & PEDIATRICS	30.00	416,662	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00		0.00	0	2.00
	TOTALS	416,662	TOTALS		416,662	
C - INTEREST						
1.00	ADMINISTRATIVE & GENERAL	5.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1.00
	TOTALS	0	TOTALS		0	
D - MEDICAL SUPPLIES						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1.00
2.00		0.00	ADMINISTRATIVE & GENERAL	5.00	0	2.00
3.00		0.00	OPERATION OF PLANT	7.00	0	3.00
4.00		0.00	HOUSEKEEPING	9.00	0	4.00
5.00		0.00	DIETARY	10.00	0	5.00
6.00		0.00	NURSING ADMINISTRATION	13.00	0	6.00
7.00		0.00	CENTRAL SERVICES & SUPPLY	14.00	0	7.00
8.00		0.00	PHARMACY	15.00	0	8.00
9.00		0.00	MEDICAL RECORDS & LIBRARY	16.00	0	9.00
10.00		0.00	ADULTS & PEDIATRICS	30.00	0	10.00
11.00		0.00	OPERATING ROOM	50.00	0	11.00
12.00		0.00	RADIOLOGY-DIAGNOSTIC	54.00	0	12.00
13.00		0.00	LABORATORY	60.00	0	13.00
14.00		0.00	RESPIRATORY THERAPY	65.00	0	14.00
15.00		0.00	PHYSICAL THERAPY	66.00	0	15.00
16.00		0.00	EMERGENCY	91.00	0	16.00
17.00		0.00	OTHER NONREIMBURSABLE - CLINIC	194.00	0	17.00
	TOTALS	0	TOTALS		0	
E - OT EXPENSE						
1.00	OCCUPATIONAL THERAPY	67.00	PHYSICAL THERAPY	66.00	315	1.00
	TOTALS	315	TOTALS		315	
500.00	Grand Total: Increases	416,977	Grand Total: Decreases		416,977	500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151316

Period:
From 07/01/2012
To 06/30/2013

Worksheet A-7
Part I
Date/Time Prepared:
11/26/2013 9:24 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	160,146	0	0	0	1.00
2.00	Land Improvements	66,241	0	0	0	2.00
3.00	Buildings and Fixtures	1,281,956	0	0	0	3.00
4.00	Building Improvements	603,153	21,300	0	21,300	4.00
5.00	Fixed Equipment	740,326	18,038	0	18,038	5.00
6.00	Movable Equipment	6,080,355	64,507	0	64,507	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	8,932,177	103,845	0	103,845	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	8,932,177	103,845	0	103,845	10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	160,146	0			1.00
2.00	Land Improvements	66,241	0			2.00
3.00	Buildings and Fixtures	1,281,956	0			3.00
4.00	Building Improvements	624,453	0			4.00
5.00	Fixed Equipment	758,364	0			5.00
6.00	Movable Equipment	6,144,862	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	9,036,022	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	9,036,022	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151316

Period:
From 07/01/2012
To 06/30/2013

Worksheet A-7
Part II
Date/Time Prepared:
11/26/2013 9:24 am

Cost Center Description		SUMMARY OF CAPITAL					
		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	148,782	1,053,300	17,377	25,704	17,678	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	349,888	427,007	0	1,651	0	2.00
3.00	Total (sum of lines 1-2)	498,670	1,480,307	17,377	27,355	17,678	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	1,262,841				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	778,546				2.00
3.00	Total (sum of lines 1-2)	0	2,041,387				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS	Provider CCN: 151316	Period: From 07/01/2012 To 06/30/2013	Worksheet A-7 Part III Date/Time Prepared: 11/26/2013 9:24 am
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Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL			
	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	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	1,262,841	0	1,262,841	0.546230	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,049,079	0	1,049,079	0.453770	0	2.00
3.00	Total (sum of lines 1-2)	2,311,920	0	2,311,920	1.000000	0	3.00
Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL			
	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	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	142,418	1,053,300	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	347,641	427,007	2.00
3.00	Total (sum of lines 1-2)	0	0	0	490,059	1,480,307	3.00
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	17,377	25,704	17,678	0	1,256,477	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	-8,765	1,651	0	0	767,534	2.00
3.00	Total (sum of lines 1-2)	8,612	27,355	17,678	0	2,024,011	3.00

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.
			Cost Center	Line #	
			1.00	2.00	
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0 1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-8,765	CAP REL COSTS-MVBLE EQUIP	2.00	11 2.00
3.00 Investment income - other (chapter 2)	B	-1,302	ADMINISTRATIVE & GENERAL	5.00	0 3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0		0.00	0 4.00
5.00 Refunds and rebates of expenses (chapter 8)		0		0.00	0 5.00
6.00 Rental of provider space by suppliers (chapter 8)		0		0.00	0 6.00
7.00 Telephone services (pay stations excluded) (chapter 21)	A	-3,193	ADMINISTRATIVE & GENERAL	5.00	0 7.00
8.00 Television and radio service (chapter 21)	A	-2,626	ADMINISTRATIVE & GENERAL	5.00	0 8.00
9.00 Parking lot (chapter 21)		0		0.00	0 9.00
10.00 Provider-based physician adjustment	A-8-2	-847,837			0 10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0		0.00	0 11.00
12.00 Related organization transactions (chapter 10)	A-8-1	1,569,746			0 12.00
13.00 Laundry and linen service		0		0.00	0 13.00
14.00 Cafeteria-employees and guests	B	-106,031	CAFETERIA	11.00	0 14.00
15.00 Rental of quarters to employee and others		0		0.00	0 15.00
16.00 Sale of medical and surgical supplies to other than patients		0		0.00	0 16.00
17.00 Sale of drugs to other than patients	B	-10,814	PHARMACY	15.00	0 17.00
18.00 Sale of medical records and abstracts	B	-9,354	ADMINISTRATIVE & GENERAL	5.00	0 18.00
19.00 Nursing school (tuition, fees, books, etc.)		0		0.00	0 19.00
20.00 Vending machines		0		0.00	0 20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0 21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0 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 - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0 26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0 27.00
28.00 Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00	28.00
29.00 Physicians' assistant		0		0.00	0 29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	-667	OCCUPATIONAL THERAPY	67.00	30.00
30.99 Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00	30.99
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	0 32.00
33.00 MISC INCOME	B	-10,481	CENTRAL SERVICES & SUPPLY	14.00	0 33.00
33.01 MISC INCOME	B	-2,440	PHYSICAL THERAPY	66.00	0 33.01

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ADJUSTMENTS TO EXPENSES

Provider CCN: 151316

Period:
From 07/01/2012
To 06/30/2013

Worksheet A-8

Date/Time Prepared:
11/26/2013 9:24 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on worksheet A To/From which the Amount is to be Adjusted		Wkst. A-7 Ref.
			Cost Center	Line #	
	1.00	2.00	3.00	4.00	5.00
33.02 MISC INCOME	B	-1,810	NURSING ADMINISTRATION	13.00	0 33.02
33.03 MISC INCOME	B	-4,658	ADMINISTRATIVE & GENERAL	5.00	0 33.03
33.04 MISC INCOME	B	-676	RESPIRATORY THERAPY	65.00	0 33.04
33.05 DONATION EXPENSE	A	-12,180	ADMINISTRATIVE & GENERAL	5.00	0 33.05
33.06 ATHLETIC TRAINER	A	-15,654	PHYSICAL THERAPY	66.00	0 33.06
33.07 PROVIDER TAX ADJ	A	-1,001,274	ADMINISTRATIVE & GENERAL	5.00	0 33.07
33.08 LOBBYING	A	-644	ADMINISTRATIVE & GENERAL	5.00	0 33.08
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200.)		-470,660			50.00

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED					
HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	2,752,439	1,802,574
2.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	119,995	119,995
3.00	194.00	OTHER NONREIMBURSABLE - CLINIC	HOME OFFICE	233,713	0
4.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	SVH CHARGEBACKS	381,393	381,393
4.01	5.00	ADMINISTRATIVE & GENERAL	SVH CHARGEBACKS	1,100,315	1,100,315
4.02	9.00	HOUSEKEEPING	SVH CHARGEBACKS	-77,366	-77,366
4.03	14.00	CENTRAL SERVICES & SUPPLY	SVH CHARGEBACKS	124,511	124,511
4.04	15.00	PHARMACY	SVH CHARGEBACKS	6,944	6,944
4.05	16.00	MEDICAL RECORDS & LIBRARY	SVH CHARGEBACKS	162,660	162,660
4.06	30.00	ADULTS & PEDIATRICS	SVH CHARGEBACKS	2,164	2,164
4.07	54.00	RADIOLOGY-DIAGNOSTIC	SVH CHARGEBACKS	21,651	21,651
4.08	65.00	RESPIRATORY THERAPY	SVH CHARGEBACKS	106,195	106,195
4.09	194.00	OTHER NONREIMBURSABLE - CLINIC	SVH CHARGEBACKS	-1,430	-1,430
4.10	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE SELF INSURANCE	1,369,853	862,717
4.11	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE MARKETING	0	119,776
4.12	1.00	CAP REL COSTS-BLDG & FIXT	ASCENSION INTEREST	8,765	15,129
4.13	5.00	ADMINISTRATIVE & GENERAL	ASCENSION INTEREST	1,302	2,247
4.14	7.00	OPERATION OF PLANT	TRIMEDEX	429,606	423,489
4.15	4.00	EMPLOYEE BENEFITS DEPARTMENT	ASCENSION PENSION	192,540	192,540
4.16	1.00	CAP REL COSTS-BLDG & FIXT	ASCENSION PAYMENTS	25,704	25,704
4.17	2.00	CAP REL COSTS-MVBLE EQUIP	ASCENSION PAYMENTS	1,651	1,651
4.18	4.00	EMPLOYEE BENEFITS DEPARTMENT	ASCENSION PAYMENTS	54,206	54,206
4.19	5.00	ADMINISTRATIVE & GENERAL	ASCENSION PAYMENTS	-3,953	-3,953
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to worksheet A-8, column 2, line 12.			7,012,858	5,443,112

* 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	Related Organization(s) and/or Home Office	
			Name	Percentage of Ownership
1.00	2.00	3.00	4.00	5.00
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		0.00	ST. VINCENT HEA	100.00	6.00
7.00	B		0.00	ST. VINCENT HOS	100.00	7.00
8.00	G		0.00	ASCENSION	100.00	8.00
9.00	A		0.00	TRIMEDX	0.00	9.00
10.00			0.00		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.

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	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	949,865	9	1.00
2.00	0	0	2.00
3.00	233,713	0	3.00
4.00	0	0	4.00
4.01	0	0	4.01
4.02	0	0	4.02
4.03	0	0	4.03
4.04	0	0	4.04
4.05	0	0	4.05
4.06	0	0	4.06
4.07	0	0	4.07
4.08	0	0	4.08
4.09	0	0	4.09
4.10	507,136	0	4.10
4.11	-119,776	0	4.11
4.12	-6,364	9	4.12
4.13	-945	0	4.13
4.14	6,117	0	4.14
4.15	0	0	4.15
4.16	0	9	4.16
4.17	0	9	4.17
4.18	0	0	4.18
4.19	0	0	4.19
5.00	1,569,746		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	Type of Business	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	ADMINISTRATION	6.00
7.00	HOSPITAL	7.00
8.00	ADMINISTRATION	8.00
9.00	TECHNOLOGY MGMT	9.00
10.00		10.00
100.00		100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151316

Period:
From 07/01/2012
To 06/30/2013

Worksheet A-8-2

Date/Time Prepared:
11/26/2013 9:24 am

	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
Wkst. A Line #	Cost Center/Physician Identifier		Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
1.00	5.00	ADMINISTRATIVE & GENERAL	27,062	27,062	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	8,535	8,535	0	0	0	2.00
3.00	50.00	OPERATING ROOM	594,669	594,669	0	0	0	3.00
4.00	66.00	PHYSICAL THERAPY	1,277	1,277	0	0	0	4.00
5.00	91.00	EMERGENCY	559,443	70,115	489,328	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	146,179	146,179	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,337,165	847,837	489,328			200.00

	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
Wkst. A Line #	Cost Center/Physician Identifier		Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	66.00	PHYSICAL THERAPY	0	0	0	0	0	4.00
5.00	91.00	EMERGENCY	0	0	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	1.00	2.00	15.00	16.00	17.00	18.00	
Wkst. A Line #	Cost Center/Physician Identifier		Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	27,062	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	8,535	2.00
3.00	50.00	OPERATING ROOM	0	0	0	594,669	3.00
4.00	66.00	PHYSICAL THERAPY	0	0	0	1,277	4.00
5.00	91.00	EMERGENCY	0	0	0	70,115	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	146,179	6.00
7.00	0.00		0	0	0	0	7.00
8.00	0.00		0	0	0	0	8.00
9.00	0.00		0	0	0	0	9.00
10.00	0.00		0	0	0	0	10.00
200.00			0	0	0	847,837	200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 151316	Period: From 07/01/2012 To 06/30/2013	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/26/2013 9:24 am		
			Physical Therapy	Cost		
				1.00		
PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)			52	1.00	
2.00	Line 1 multiplied by 15 hours per week			780	2.00	
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)			344	3.00	
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)			0	4.00	
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)			0	5.00	
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)			0	6.00	
7.00	Standard travel expense rate			5.21	7.00	
8.00	Optional travel expense rate per mile			0.00	8.00	
		Supervisors	Therapists	Assistants	Aides	Trainees
		1.00	2.00	3.00	4.00	5.00
9.00	Total hours worked	0.00	6,450.63	1,469.35	2,339.85	0.00
10.00	AHSEA (see instructions)	0.00	74.92	56.19	37.46	0.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	37.46	37.46	28.10		
12.00	Number of travel hours (provider site)	0	0	0		12.00
12.01	Number of travel hours (offsite)	0	0	0		12.01
13.00	Number of miles driven (provider site)	0	0	0		13.00
13.01	Number of miles driven (offsite)	0	0	0		13.01
				1.00		
Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)			0	14.00	
15.00	Therapists (column 2, line 9 times column 2, line 10)			483,281	15.00	
16.00	Assistants (column 3, line 9 times column 3, line 10)			82,563	16.00	
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)			565,844	17.00	
18.00	Aides (column 4, line 9 times column 4, line 10)			87,651	18.00	
19.00	Trainees (column 5, line 9 times column 5, line 10)			0	19.00	
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)			653,495	20.00	
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)			0.00	21.00	
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)			0	22.00	
23.00	Total salary equivalency (see instructions)			653,495	23.00	
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)			12,886	24.00	
25.00	Assistants (line 4 times column 3, line 11)			0	25.00	
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)			12,886	26.00	
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)			1,792	27.00	
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)			14,678	28.00	
Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)			0	29.00	
30.00	Assistants (column 3, line 10 times column 3, line 12)			0	30.00	
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)			0	31.00	
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)			0	32.00	
33.00	Standard travel allowance and standard travel expense (line 28)			14,678	33.00	
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)			0	34.00	
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)			0	35.00	
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)			0	36.00	
37.00	Assistants (line 6 times column 3, line 11)			0	37.00	
38.00	Subtotal (sum of lines 36 and 37)			0	38.00	
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)			0	39.00	
Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)			0	40.00	
41.00	Assistants (column 3, line 12.01 times column 3, line 10)			0	41.00	
42.00	Subtotal (sum of lines 40 and 41)			0	42.00	
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)			0	43.00	
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)			0	44.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)			0	45.00	

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 151316	Period: From 07/01/2012 To 06/30/2013	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/26/2013 9:24 am
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		Physical Therapy				Cost	
						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
PART V - OVERTIME COMPUTATION							
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00	0.00	48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00	0.00	49.00
CALCULATION OF LIMIT							
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
DETERMINATION OF OVERTIME ALLOWANCE							
52.00	Adjusted hourly salary equivalency amount (see instructions)	74.92	56.19	37.46	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00
						1.00	
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT							
57.00	Salary equivalency amount (from line 23)					653,495	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					14,678	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)					0	59.00
60.00	Overtime allowance (from column 5, line 56)					0	60.00
61.00	Equipment cost (see instructions)					0	61.00
62.00	Supplies (see instructions)					0	62.00
63.00	Total allowance (sum of lines 57-62)					668,173	63.00
64.00	Total cost of outside supplier services (from your records)					652,162	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)					0	65.00
LINE 33 CALCULATION							
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others					12,886	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					1,792	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27					14,678	100.02
LINE 34 CALCULATION							
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					1,792	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	101.01
101.02	Line 34 = sum of lines 27 and 31					1,792	101.02
LINE 35 CALCULATION							
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others					0	102.01
102.02	Line 35 = sum of lines 31 and 32					0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 151316	Period: From 07/01/2012 To 06/30/2013	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/26/2013 9:24 am			
			Occupational Therapy	Cost			
				1.00			
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)			52	1.00		
2.00	Line 1 multiplied by 15 hours per week			780	2.00		
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)			246	3.00		
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)			0	4.00		
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)			0	5.00		
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)			0	6.00		
7.00	Standard travel expense rate			5.21	7.00		
8.00	Optional travel expense rate per mile			0.00	8.00		
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	2,170.18	6.97	643.21	0.00	9.00
10.00	AHSEA (see instructions)	0.00	71.02	53.27	35.51	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	35.51	35.51	26.64			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)				0	14.00	
15.00	Therapists (column 2, line 9 times column 2, line 10)				154,126	15.00	
16.00	Assistants (column 3, line 9 times column 3, line 10)				371	16.00	
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)				154,497	17.00	
18.00	Aides (column 4, line 9 times column 4, line 10)				22,840	18.00	
19.00	Trainees (column 5, line 9 times column 5, line 10)				0	19.00	
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)				177,337	20.00	
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)				0.00	21.00	
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)				0	22.00	
23.00	Total salary equivalency (see instructions)				177,337	23.00	
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)				8,735	24.00	
25.00	Assistants (line 4 times column 3, line 11)				0	25.00	
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)				8,735	26.00	
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)				1,282	27.00	
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)				10,017	28.00	
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)				0	29.00	
30.00	Assistants (column 3, line 10 times column 3, line 12)				0	30.00	
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)				0	31.00	
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)				0	32.00	
33.00	Standard travel allowance and standard travel expense (line 28)				10,017	33.00	
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)				0	34.00	
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)				0	35.00	
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)				0	36.00	
37.00	Assistants (line 6 times column 3, line 11)				0	37.00	
38.00	Subtotal (sum of lines 36 and 37)				0	38.00	
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)				0	39.00	
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)				0	40.00	
41.00	Assistants (column 3, line 12.01 times column 3, line 10)				0	41.00	
42.00	Subtotal (sum of lines 40 and 41)				0	42.00	
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)				0	43.00	
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)				0	44.00	

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 151316	Period: From 07/01/2012 To 06/30/2013	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/26/2013 9:24 am
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	Occupational Therapy	Cost
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		1.00
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45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)	0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)	0	46.00

	Therapists	Assistants	Aides	Trainees	Total
	1.00	2.00	3.00	4.00	5.00

PART V - OVERTIME COMPUTATION

47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00

CALCULATION OF LIMIT

50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00

DETERMINATION OF OVERTIME ALLOWANCE

52.00	Adjusted hourly salary equivalency amount (see instructions)	71.02	53.27	35.51	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00
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Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57.00	Salary equivalency amount (from line 23)		177,337	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))		10,017	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)		0	59.00
60.00	Overtime allowance (from column 5, line 56)		0	60.00
61.00	Equipment cost (see instructions)		0	61.00
62.00	Supplies (see instructions)		0	62.00
63.00	Total allowance (sum of lines 57-62)		187,354	63.00
64.00	Total cost of outside supplier services (from your records)		188,021	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)		667	65.00

LINE 33 CALCULATION

100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others		8,735	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others		1,282	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27		10,017	100.02

LINE 34 CALCULATION

101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others		1,282	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others		0	101.01
101.02	Line 34 = sum of lines 27 and 31		1,282	101.02

LINE 35 CALCULATION

102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others		0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others		0	102.01
102.02	Line 35 = sum of lines 31 and 32		0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151316

Period:
From 07/01/2012
To 06/30/2013

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Cost Center Description	Net Expenses for Cost Allocation (from wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal			
		BLDG & FIXT	MVBLE EQUIP					
	0	1.00	2.00	4.00	4A			
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,256,477	1,256,477			1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP	767,534		767,534		2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,063,975	13,000	7,941	3,084,916	4.00	
5.00	00500	ADMINISTRATIVE & GENERAL	4,569,758	117,443	71,742	694,721	5.00	
7.00	00700	OPERATION OF PLANT	1,499,510	129,109	78,868	87,818	1,795,305	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	108,776	9,805	5,990	0	124,571	8.00
9.00	00900	HOUSEKEEPING	518,601	22,813	13,936	0	555,350	9.00
10.00	01000	DIETARY	117,758	31,049	18,966	0	167,773	10.00
11.00	01100	CAFETERIA	355,274	14,602	8,920	0	378,796	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	884,818	28,976	17,700	323,301	1,254,795	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	183,133	42,000	25,656	56,853	307,642	14.00
15.00	01500	PHARMACY	835,570	21,628	13,212	101,712	972,122	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	164,662	24,493	14,962	28,197	232,314	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,484,350	194,676	118,920	528,799	2,326,745	30.00
43.00	04300	NURSERY	163,424	3,917	2,393	55,038	224,772	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	724,041	82,273	50,257	161,862	1,018,433	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	307,524	17,153	10,478	103,568	438,723	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	799,549	57,520	35,137	241,342	1,133,548	54.00
60.00	06000	LABORATORY	1,455,742	24,454	14,938	222,015	1,717,149	60.00
65.00	06500	RESPIRATORY THERAPY	289,657	12,105	7,395	60,868	370,025	65.00
66.00	06600	PHYSICAL THERAPY	676,080	24,329	14,861	425	715,695	66.00
67.00	06700	OCCUPATIONAL THERAPY	197,820	1,468	897	120	200,305	67.00
68.00	06800	SPEECH PATHOLOGY	65,757	4,545	2,777	24,673	97,752	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	174,632	0	0	0	174,632	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	107,337	0	0	0	107,337	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	1,656,556	40,501	24,740	362,294	2,084,091	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)	22,428,315	917,859	560,686	3,053,606	21,851,539	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,255	2,599	0	6,854	190.00
194.00	07950	OTHER NONREIMBURSABLE - CLINIC	625,566	329,676	201,386	31,310	1,187,938	194.00
194.01	07951	OTHER NONREIMBURSABLE - FOUNDATION	1,431	4,687	2,863	0	8,981	194.01
194.02	07952	OTHER NONREIMBURSABLE - MARKETING	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	23,055,312	1,256,477	767,534	3,084,916	23,055,312	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151316

Period:
From 07/01/2012
To 06/30/2013

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Part I
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Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,453,664				5.00
7.00	00700	OPERATION OF PLANT	556,254	2,351,559			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	38,597	23,129	186,297		8.00
9.00	00900	HOUSEKEEPING	172,069	53,813	0	781,232	9.00
10.00	01000	DIETARY	51,982	73,238	5,585	25,154	323,732
11.00	01100	CAFETERIA	117,365	34,443	0	11,830	0
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	388,783	68,349	0	23,475	0
14.00	01400	CENTRAL SERVICES & SUPPLY	95,319	99,070	1,857	34,026	0
15.00	01500	PHARMACY	301,200	51,017	0	17,522	0
16.00	01600	MEDICAL RECORDS & LIBRARY	71,980	57,776	0	19,843	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	720,918	459,205	67,069	157,717	323,732
43.00	04300	NURSERY	69,643	9,240	0	3,174	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	315,549	194,067	16,767	66,653	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	135,933	40,461	0	13,897	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	351,216	135,680	0	46,600	0
60.00	06000	LABORATORY	532,038	57,683	0	19,812	0
65.00	06500	RESPIRATORY THERAPY	114,648	28,554	0	9,807	0
66.00	06600	PHYSICAL THERAPY	221,750	57,387	33,426	19,710	0
67.00	06700	OCCUPATIONAL THERAPY	62,062	3,463	9,421	1,189	0
68.00	06800	SPEECH PATHOLOGY	30,287	10,722	0	3,682	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	54,108	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	33,257	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	645,731	95,533	27,950	32,812	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	5,080,689	1,552,830	162,075	506,903	323,732
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,124	10,037	0	3,447	0
194.00	07950	OTHER NONREIMBURSABLE - CLINIC	368,068	777,637	24,222	267,085	0
194.01	07951	OTHER NONREIMBURSABLE - FOUNDATION	2,783	11,055	0	3,797	0
194.02	07952	OTHER NONREIMBURSABLE - MARKETING	0	0	0	0	0
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	5,453,664	2,351,559	186,297	781,232	323,732

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151316

Period:
From 07/01/2012
To 06/30/2013

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Cost Center Description		CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		11.00	12.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	542,434					11.00
12.00	01200	0	0				12.00
13.00	01300	61,943	0	1,797,345			13.00
14.00	01400	22,072	0	0	559,986		14.00
15.00	01500	19,298	0	0	1,754	1,362,913	15.00
16.00	01600	8,528	0	0	67	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	131,262	0	547,905	123,676	0	30.00
43.00	04300	11,888	0	49,622	21,741	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	38,542	0	160,880	135,620	0	50.00
52.00	05200	22,372	0	93,383	40,912	0	52.00
54.00	05400	54,087	0	225,766	31,059	0	54.00
60.00	06000	56,218	0	234,660	40,525	0	60.00
65.00	06500	13,235	0	55,243	1,210	0	65.00
66.00	06600	0	0	0	1,139	0	66.00
67.00	06700	0	0	0	322	0	67.00
68.00	06800	4,423	0	18,461	0	0	68.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	1,362,913	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	89,673	0	374,306	153,848	0	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
118.00		533,541	0	1,760,226	551,873	1,362,913	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
194.00	07950	8,893	0	37,119	8,113	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		542,434	0	1,797,345	559,986	1,362,913	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151316

Period:
From 07/01/2012
To 06/30/2013

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description		MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		16.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
12.00	01200	MAINTENANCE OF PERSONNEL				12.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	390,508			16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	29,217	4,887,446	0	4,887,446
43.00	04300	NURSERY	4,040	394,120	0	394,120
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	52,311	1,998,822	0	1,998,822
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,601	793,282	0	793,282
54.00	05400	RADIOLOGY-DIAGNOSTIC	95,841	2,073,797	0	2,073,797
60.00	06000	LABORATORY	77,661	2,735,746	0	2,735,746
65.00	06500	RESPIRATORY THERAPY	10,507	603,229	0	603,229
66.00	06600	PHYSICAL THERAPY	25,118	1,074,225	0	1,074,225
67.00	06700	OCCUPATIONAL THERAPY	7,085	283,847	0	283,847
68.00	06800	SPEECH PATHOLOGY	1,064	166,391	0	166,391
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	228,740	0	228,740
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	140,594	0	140,594
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,362,913	0	1,362,913
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	77,439	3,581,383	0	3,581,383
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0	
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	387,884	20,324,535	0	20,324,535
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	22,462	0	22,462
194.00	07950	OTHER NONREIMBURSABLE - CLINIC	2,624	2,681,699	0	2,681,699
194.01	07951	OTHER NONREIMBURSABLE - FOUNDATION	0	26,616	0	26,616
194.02	07952	OTHER NONREIMBURSABLE - MARKETING	0	0	0	0
200.00		Cross Foot Adjustments		0	0	0
201.00		Negative Cost Centers	0	0	0	0
202.00		TOTAL (sum lines 118-201)	390,508	23,055,312	0	23,055,312

Cost Center Description		Statistics Code	Statistics Description	
		1.00	2.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	1	SQUARE FEET	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1	SQUARE FEET	2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	5	GROSS SALARIES	4.00
5.00	ADMINISTRATIVE & GENERAL	-5	ACCUM. COST	5.00
7.00	OPERATION OF PLANT	1	SQUARE FEET	7.00
8.00	LAUNDRY & LINEN SERVICE	8	POUNDS OF LAUNDRY	8.00
9.00	HOUSEKEEPING	1	SQUARE FEET	9.00
10.00	DIETARY	10	MEALS SERVED	10.00
11.00	CAFETERIA	11	HOURS OF SERVICE	11.00
12.00	MAINTENANCE OF PERSONNEL	12	NUMBER HOUSED	12.00
13.00	NURSING ADMINISTRATION	13	DIRECT NURS. HRS.	13.00
14.00	CENTRAL SERVICES & SUPPLY	14	COSTED REQUIS.	14.00
15.00	PHARMACY	15	COSTED REQUIS.	15.00
16.00	MEDICAL RECORDS & LIBRARY	16	MEDICAL SUPPLIES	16.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151316

Period:
From 07/01/2012
To 06/30/2013

Worksheet B
Part II
Date/Time Prepared:
11/26/2013 9:24 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	2A	4.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	13,000	7,941	20,941	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	317,330	117,443	71,742	506,515	5.00
7.00 00700	OPERATION OF PLANT	0	129,109	78,868	207,977	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	9,805	5,990	15,795	8.00
9.00 00900	HOUSEKEEPING	0	22,813	13,936	36,749	9.00
10.00 01000	DIETARY	0	31,049	18,966	50,015	10.00
11.00 01100	CAFETERIA	0	14,602	8,920	23,522	11.00
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00 01300	NURSING ADMINISTRATION	0	28,976	17,700	46,676	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	42,000	25,656	67,656	14.00
15.00 01500	PHARMACY	0	21,628	13,212	34,840	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	24,493	14,962	39,455	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	194,676	118,920	313,596	30.00
43.00 04300	NURSERY	0	3,917	2,393	6,310	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	82,273	50,257	132,530	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	17,153	10,478	27,631	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	57,520	35,137	92,657	54.00
60.00 06000	LABORATORY	0	24,454	14,938	39,392	60.00
65.00 06500	RESPIRATORY THERAPY	0	12,105	7,395	19,500	65.00
66.00 06600	PHYSICAL THERAPY	0	24,329	14,861	39,190	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	1,468	897	2,365	67.00
68.00 06800	SPEECH PATHOLOGY	0	4,545	2,777	7,322	68.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	0	40,501	24,740	65,241	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	92.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	317,330	917,859	560,686	1,795,875	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,255	2,599	6,854	190.00
194.00 07950	OTHER NONREIMBURSABLE - CLINIC	0	329,676	201,386	531,062	194.00
194.01 07951	OTHER NONREIMBURSABLE - FOUNDATION	0	4,687	2,863	7,550	194.01
194.02 07952	OTHER NONREIMBURSABLE - MARKETING	0	0	0	0	194.02
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	317,330	1,256,477	767,534	2,341,341	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151316

Period:
From 07/01/2012
To 06/30/2013

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	511,231				5.00
7.00	00700	OPERATION OF PLANT	52,143	260,716			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,618	2,564	21,977		8.00
9.00	00900	HOUSEKEEPING	16,130	5,966	0	58,845	9.00
10.00	01000	DIETARY	4,873	8,120	659	1,895	65,562
11.00	01100	CAFETERIA	11,002	3,819	0	891	0
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	36,444	7,578	0	1,768	0
14.00	01400	CENTRAL SERVICES & SUPPLY	8,935	10,984	219	2,563	0
15.00	01500	PHARMACY	28,234	5,656	0	1,320	0
16.00	01600	MEDICAL RECORDS & LIBRARY	6,747	6,406	0	1,495	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	67,588	50,912	7,913	11,880	65,562
43.00	04300	NURSERY	6,528	1,024	0	239	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	29,579	21,516	1,978	5,021	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	12,742	4,486	0	1,047	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	32,923	15,043	0	3,510	0
60.00	06000	LABORATORY	49,873	6,395	0	1,492	0
65.00	06500	RESPIRATORY THERAPY	10,747	3,166	0	739	0
66.00	06600	PHYSICAL THERAPY	20,787	6,362	3,943	1,485	0
67.00	06700	OCCUPATIONAL THERAPY	5,818	384	1,111	90	0
68.00	06800	SPEECH PATHOLOGY	2,839	1,189	0	277	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,072	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,117	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	60,530	10,592	3,297	2,471	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	476,269	172,162	19,120	38,183	65,562
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	199	1,113	0	260	0
194.00	07950	OTHER NONREIMBURSABLE - CLINIC	34,502	86,215	2,857	20,116	0
194.01	07951	OTHER NONREIMBURSABLE - FOUNDATION	261	1,226	0	286	0
194.02	07952	OTHER NONREIMBURSABLE - MARKETING	0	0	0	0	0
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	511,231	260,716	21,977	58,845	65,562

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151316

Period:
From 07/01/2012
To 06/30/2013

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		11.00	12.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	39,234					11.00
12.00	01200	0	0				12.00
13.00	01300	4,480	0	99,141			13.00
14.00	01400	1,596	0	0	92,339		14.00
15.00	01500	1,396	0	0	289	72,425	15.00
16.00	01600	617	0	0	11	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	9,495	0	30,223	20,394	0	30.00
43.00	04300	860	0	2,737	3,585	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	2,788	0	8,874	22,363	0	50.00
52.00	05200	1,618	0	5,151	6,746	0	52.00
54.00	05400	3,912	0	12,453	5,121	0	54.00
60.00	06000	4,066	0	12,944	6,682	0	60.00
65.00	06500	957	0	3,047	200	0	65.00
66.00	06600	0	0	0	188	0	66.00
67.00	06700	0	0	0	53	0	67.00
68.00	06800	320	0	1,018	0	0	68.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	72,425	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	6,486	0	20,647	25,369	0	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
118.00		38,591	0	97,094	91,001	72,425	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
194.00	07950	643	0	2,047	1,338	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		39,234	0	99,141	92,339	72,425	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151316

Period:
From 07/01/2012
To 06/30/2013

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		16.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
12.00	01200	MAINTENANCE OF PERSONNEL				12.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	54,922			16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,108	585,261	0	30.00
43.00	04300	NURSERY	568	22,225	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,356	233,104	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,069	61,193	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,488	180,745	0	54.00
60.00	06000	LABORATORY	10,920	133,271	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,477	40,246	0	65.00
66.00	06600	PHYSICAL THERAPY	3,532	75,490	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	996	10,818	0	67.00
68.00	06800	SPEECH PATHOLOGY	150	13,282	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,072	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,117	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	72,425	0	73.00
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	10,889	207,981	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0	92.00
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	54,553	1,644,230	0	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	8,426	0	190.00
194.00	07950	OTHER NONREIMBURSABLE - CLINIC	369	679,362	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - FOUNDATION	0	9,323	0	194.01
194.02	07952	OTHER NONREIMBURSABLE - MARKETING	0	0	0	194.02
200.00		Cross Foot Adjustments		0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	54,922	2,341,341	0	202.00

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	160,051			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		160,051		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,656	1,656	8,104,148	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	14,960	14,960	1,825,052	5.00
7.00	00700	OPERATION OF PLANT	16,446	16,446	230,699	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,249	1,249	0	8.00
9.00	00900	HOUSEKEEPING	2,906	2,906	0	9.00
10.00	01000	DIETARY	3,955	3,955	0	10.00
11.00	01100	CAFETERIA	1,860	1,860	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	3,691	3,691	849,319	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,350	5,350	149,355	14.00
15.00	01500	PHARMACY	2,755	2,755	267,201	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,120	3,120	74,075	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	24,798	24,798	1,389,168	30.00
43.00	04300	NURSERY	499	499	144,586	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,480	10,480	425,214	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,185	2,185	272,076	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,327	7,327	634,010	54.00
60.00	06000	LABORATORY	3,115	3,115	583,238	60.00
65.00	06500	RESPIRATORY THERAPY	1,542	1,542	159,902	65.00
66.00	06600	PHYSICAL THERAPY	3,099	3,099	1,117	66.00
67.00	06700	OCCUPATIONAL THERAPY	187	187	315	67.00
68.00	06800	SPEECH PATHOLOGY	579	579	64,816	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	5,159	5,159	951,754	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	116,918	116,918	8,021,897	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	542	542	0	190.00
194.00	07950	OTHER NONREIMBURSABLE - CLINIC	41,994	41,994	82,251	194.00
194.01	07951	OTHER NONREIMBURSABLE - FOUNDATION	597	597	0	194.01
194.02	07952	OTHER NONREIMBURSABLE - MARKETING	0	0	0	194.02
200.00		Cross Foot Adjustments				200.00
201.00		Negative Cost Centers				201.00
202.00		Cost to be allocated (per wkst. B, Part I)	1,256,477	767,534	3,084,916	202.00
203.00		Unit cost multiplier (wkst. B, Part I)	7.850479	4.795559	0.380659	203.00
204.00		Cost to be allocated (per wkst. B, Part II)			20,941	204.00
205.00		Unit cost multiplier (wkst. B, Part II)			0.002584	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151316

Period:
From 07/01/2012
To 06/30/2013

Worksheet B-1

Date/Time Prepared:
11/26/2013 9:24 am

Cost Center Description		OPERATION OF PLANT (SQURE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQURE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS OF SERVICE)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	126,989				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,249	13,744			8.00
9.00	00900	HOUSEKEEPING	2,906		122,834		9.00
10.00	01000	DIETARY	3,955	412	3,955	13,601	10.00
11.00	01100	CAFETERIA	1,860	0	1,860	0	208,250
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	3,691	0	3,691	0	23,781
14.00	01400	CENTRAL SERVICES & SUPPLY	5,350	137	5,350	0	8,474
15.00	01500	PHARMACY	2,755	0	2,755	0	7,409
16.00	01600	MEDICAL RECORDS & LIBRARY	3,120	0	3,120	0	3,274
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	24,798	4,948	24,798	13,601	50,394
43.00	04300	NURSERY	499	0	499	0	4,564
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	10,480	1,237	10,480	0	14,797
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,185	0	2,185	0	8,589
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,327	0	7,327	0	20,765
60.00	06000	LABORATORY	3,115	0	3,115	0	21,583
65.00	06500	RESPIRATORY THERAPY	1,542	0	1,542	0	5,081
66.00	06600	PHYSICAL THERAPY	3,099	2,466	3,099	0	0
67.00	06700	OCCUPATIONAL THERAPY	187	695	187	0	0
68.00	06800	SPEECH PATHOLOGY	579	0	579	0	1,698
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	5,159	2,062	5,159	0	34,427
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	83,856	11,957	79,701	13,601	204,836
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	542	0	542	0	0
194.00	07950	OTHER NONREIMBURSABLE - CLINIC	41,994	1,787	41,994	0	3,414
194.01	07951	OTHER NONREIMBURSABLE - FOUNDATION	597	0	597	0	0
194.02	07952	OTHER NONREIMBURSABLE - MARKETING	0	0	0	0	0
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,351,559	186,297	781,232	323,732	542,434
203.00		Unit cost multiplier (Wkst. B, Part I)	18.517817	13.554788	6.360063	23.802073	2.604725
204.00		Cost to be allocated (per Wkst. B, Part II)	260,716	21,977	58,845	65,562	39,234
205.00		Unit cost multiplier (Wkst. B, Part II)	2.053060	1.599025	0.479061	4.820381	0.188399

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151316

Period:
From 07/01/2012
To 06/30/2013

Worksheet B-1

Date/Time Prepared:
11/26/2013 9:24 am

Cost Center Description		MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (MEDICAL SUPPLIES)	
		12.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0				12.00
13.00	01300	NURSING ADMINISTRATION	0	165,312			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	290,588		14.00
15.00	01500	PHARMACY	0	0	910	1,000	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	35	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	50,394	64,178	0	30.00
43.00	04300	NURSERY	0	4,564	11,282	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	14,797	70,376	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	8,589	21,230	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	20,765	16,117	0	54.00
60.00	06000	LABORATORY	0	21,583	21,029	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	5,081	628	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	591	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	167	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,698	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,000	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0	34,427	79,835	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	161,898	286,378	1,000	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
194.00	07950	OTHER NONREIMBURSABLE - CLINIC	0	3,414	4,210	0	194.00
194.01	07951	OTHER NONREIMBURSABLE - FOUNDATION	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE - MARKETING	0	0	0	0	194.02
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per wkst. B, Part I)	0	1,797,345	559,986	1,362,913	202.00
203.00		Unit cost multiplier (wkst. B, Part I)	0.000000	10.872441	1.927079	1,362.913000	203.00
204.00		Cost to be allocated (per wkst. B, Part II)	0	99,141	92,339	72,425	204.00
205.00		Unit cost multiplier (wkst. B, Part II)	0.000000	0.599721	0.317766	72.425000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151316

Period:
From 07/01/2012
To 06/30/2013

Worksheet C
Part I
Date/Time Prepared:
11/26/2013 9:24 am

		Title XVIII		Hospital		Cost	
Cost Center Description		Total Cost (from wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
				Total Costs	RCE Disallowance		
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	4,887,446		4,887,446	0	0	30.00
43.00	04300 NURSERY	394,120		394,120	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	1,998,822		1,998,822	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	793,282		793,282	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	2,073,797		2,073,797	0	0	54.00
60.00	06000 LABORATORY	2,735,746		2,735,746	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	603,229	0	603,229	0	0	65.00
66.00	06600 PHYSICAL THERAPY	1,074,225	0	1,074,225	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	283,847	0	283,847	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	166,391	0	166,391	0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	228,740		228,740	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	140,594		140,594	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,362,913		1,362,913	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	3,581,383		3,581,383	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	712,212		712,212	0	0	92.00
200.00	Subtotal (see instructions)	21,036,747	0	21,036,747	0	0	200.00
201.00	Less Observation Beds	712,212		712,212	0	0	201.00
202.00	Total (see instructions)	20,324,535	0	20,324,535	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151316

Period:
From 07/01/2012
To 06/30/2013

Worksheet C
Part I
Date/Time Prepared:
11/26/2013 9:24 am

		Title XVIII			Hospital	Cost	
Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,680,852		3,680,852		30.00
43.00	04300	NURSERY	576,693		576,693		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,263,929	6,203,748	7,467,677	0.267663	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,077,036	8,108	1,085,144	0.731038	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	730,805	12,949,034	13,679,839	0.151595	54.00
60.00	06000	LABORATORY	986,842	10,099,648	11,086,490	0.246764	60.00
65.00	06500	RESPIRATORY THERAPY	555,663	944,196	1,499,859	0.402190	65.00
66.00	06600	PHYSICAL THERAPY	949,879	2,635,842	3,585,721	0.299584	66.00
67.00	06700	OCCUPATIONAL THERAPY	435,672	575,686	1,011,358	0.280659	67.00
68.00	06800	SPEECH PATHOLOGY	52,921	98,965	151,886	1.095499	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	767,637	946,692	1,714,329	0.133428	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	449,465	182,076	631,541	0.222621	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,165,975	3,677,820	6,843,795	0.199146	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	315,778	10,739,087	11,054,865	0.323964	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	490,035	490,035	1.453390	92.00
200.00		Subtotal (see instructions)	15,009,147	49,550,937	64,560,084		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	15,009,147	49,550,937	64,560,084		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151316

Period:
From 07/01/2012
To 06/30/2013

Worksheet C
Part I
Date/Time Prepared:
11/26/2013 9:24 am

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000			50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000			52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
60.00	06000 LABORATORY	0.000000			60.00
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800 SPEECH PATHOLOGY	0.000000			68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
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: 151316

Period:
From 07/01/2012
To 06/30/2013

Worksheet C
Part I
Date/Time Prepared:
11/26/2013 9:24 am

		Title XIX		Hospital		Cost	
Cost Center Description		Total Cost (from wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Disallowance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	4,887,446		4,887,446	0	0 30.00
43.00	04300	NURSERY	394,120		394,120	0	0 43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,998,822		1,998,822	0	0 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	793,282		793,282	0	0 52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,073,797		2,073,797	0	0 54.00
60.00	06000	LABORATORY	2,735,746		2,735,746	0	0 60.00
65.00	06500	RESPIRATORY THERAPY	603,229	0	603,229	0	0 65.00
66.00	06600	PHYSICAL THERAPY	1,074,225	0	1,074,225	0	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	283,847	0	283,847	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	166,391	0	166,391	0	0 68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	228,740		228,740	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	140,594		140,594	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,362,913		1,362,913	0	0 73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	3,581,383		3,581,383	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	712,212		712,212	0	0 92.00
200.00		Subtotal (see instructions)	21,036,747	0	21,036,747	0	0 200.00
201.00		Less Observation Beds	712,212		712,212	0	0 201.00
202.00		Total (see instructions)	20,324,535	0	20,324,535	0	0 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151316

Period:
From 07/01/2012
To 06/30/2013

Worksheet C
Part I
Date/Time Prepared:
11/26/2013 9:24 am

		Title XIX			Hospital	Cost	
Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
		9.00	10.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,680,852		3,680,852		30.00
43.00	04300	NURSERY	576,693		576,693		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,263,929	6,203,748	7,467,677	0.267663	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,077,036	8,108	1,085,144	0.731038	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	730,805	12,949,034	13,679,839	0.151595	54.00
60.00	06000	LABORATORY	986,842	10,099,648	11,086,490	0.246764	60.00
65.00	06500	RESPIRATORY THERAPY	555,663	944,196	1,499,859	0.402190	65.00
66.00	06600	PHYSICAL THERAPY	949,879	2,635,842	3,585,721	0.299584	66.00
67.00	06700	OCCUPATIONAL THERAPY	435,672	575,686	1,011,358	0.280659	67.00
68.00	06800	SPEECH PATHOLOGY	52,921	98,965	151,886	1.095499	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	767,637	946,692	1,714,329	0.133428	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	449,465	182,076	631,541	0.222621	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,165,975	3,677,820	6,843,795	0.199146	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	315,778	10,739,087	11,054,865	0.323964	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	490,035	490,035	1.453390	92.00
200.00		Subtotal (see instructions)	15,009,147	49,550,937	64,560,084		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	15,009,147	49,550,937	64,560,084		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151316

Period:
From 07/01/2012
To 06/30/2013

Worksheet C
Part I
Date/Time Prepared:
11/26/2013 9:24 am

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY	Provider CCN: 151316	Period: From 07/01/2012 To 06/30/2013	Worksheet C Part II Date/Time Prepared: 11/26/2013 9:24 am
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Cost Center Description	Title XIX			Hospital		Cost
	Total Cost (wkst. B, Part I, col. 26)	Capital Cost (wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	1,998,822	233,104	1,765,718	0	0 50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	793,282	61,193	732,089	0	0 52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	2,073,797	180,745	1,893,052	0	0 54.00
60.00	06000 LABORATORY	2,735,746	133,271	2,602,475	0	0 60.00
65.00	06500 RESPIRATORY THERAPY	603,229	40,246	562,983	0	0 65.00
66.00	06600 PHYSICAL THERAPY	1,074,225	75,490	998,735	0	0 66.00
67.00	06700 OCCUPATIONAL THERAPY	283,847	10,818	273,029	0	0 67.00
68.00	06800 SPEECH PATHOLOGY	166,391	13,282	153,109	0	0 68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	228,740	5,072	223,668	0	0 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	140,594	3,117	137,477	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,362,913	72,425	1,290,488	0	0 73.00
OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	3,581,383	207,981	3,373,402	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	712,212	0	712,212	0	0 92.00
200.00	Subtotal (sum of lines 50 thru 199)	15,755,181	1,036,744	14,718,437	0	0 200.00
201.00	Less Observation Beds	712,212	0	712,212	0	0 201.00
202.00	Total (line 200 minus line 201)	15,042,969	1,036,744	14,006,225	0	0 202.00

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

Provider CCN: 151316

Period:
From 07/01/2012
To 06/30/2013

Worksheet C
Part II
Date/Time Prepared:
11/26/2013 9:24 am

Cost Center Description		Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	Hospital	Cost
		6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	1,998,822	7,467,677	0.267663		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	793,282	1,085,144	0.731038		52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	2,073,797	13,679,839	0.151595		54.00
60.00	06000 LABORATORY	2,735,746	11,086,490	0.246764		60.00
65.00	06500 RESPIRATORY THERAPY	603,229	1,499,859	0.402190		65.00
66.00	06600 PHYSICAL THERAPY	1,074,225	3,585,721	0.299584		66.00
67.00	06700 OCCUPATIONAL THERAPY	283,847	1,011,358	0.280659		67.00
68.00	06800 SPEECH PATHOLOGY	166,391	151,886	1.095499		68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	228,740	1,714,329	0.133428		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	140,594	631,541	0.222621		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,362,913	6,843,795	0.199146		73.00
OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	3,581,383	11,054,865	0.323964		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	712,212	490,035	1.453390		92.00
200.00	Subtotal (sum of lines 50 thru 199)	15,755,181	60,302,539			200.00
201.00	Less Observation Beds	712,212	0			201.00
202.00	Total (line 200 minus line 201)	15,042,969	60,302,539			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 151316		Period: From 07/01/2012 To 06/30/2013		Worksheet D Part II Date/Time Prepared: 11/26/2013 9:24 am	
Cost Center Description		Capital Related Cost (from wkst. B, Part II, col. 26)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Hospital Inpatient Program Charges	Capital Costs (column 3 x column 4)	Cost
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	233,104	7,467,677	0.031215	401,278	12,526	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	61,193	1,085,144	0.056392	3,534	199	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	180,745	13,679,839	0.013213	290,829	3,843	54.00
60.00	06000 LABORATORY	133,271	11,086,490	0.012021	428,091	5,146	60.00
65.00	06500 RESPIRATORY THERAPY	40,246	1,499,859	0.026833	461,893	12,394	65.00
66.00	06600 PHYSICAL THERAPY	75,490	3,585,721	0.021053	163,686	3,446	66.00
67.00	06700 OCCUPATIONAL THERAPY	10,818	1,011,358	0.010697	111,328	1,191	67.00
68.00	06800 SPEECH PATHOLOGY	13,282	151,886	0.087447	31,975	2,796	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	5,072	1,714,329	0.002959	344,626	1,020	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	3,117	631,541	0.004936	279,264	1,378	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	72,425	6,843,795	0.010583	1,459,878	15,450	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	207,981	11,054,865	0.018814	20,670	389	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	490,035	0.000000	0	0	92.00
200.00	Total (lines 50-199)	1,036,744	60,302,539		3,997,052	59,778	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151316

Period:
From 07/01/2012
To 06/30/2013

Worksheet D
Part IV
Date/Time Prepared:
11/26/2013 9:24 am

Cost Center Description		Title XVIII				Hospital	Cost	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151316

Period:
From 07/01/2012
To 06/30/2013

Worksheet D
Part IV
Date/Time Prepared:
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Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Cost
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	7,467,677	0.000000	0.000000	401,278	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	1,085,144	0.000000	0.000000	3,534	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	13,679,839	0.000000	0.000000	290,829	54.00
60.00	06000 LABORATORY	0	11,086,490	0.000000	0.000000	428,091	60.00
65.00	06500 RESPIRATORY THERAPY	0	1,499,859	0.000000	0.000000	461,893	65.00
66.00	06600 PHYSICAL THERAPY	0	3,585,721	0.000000	0.000000	163,686	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	1,011,358	0.000000	0.000000	111,328	67.00
68.00	06800 SPEECH PATHOLOGY	0	151,886	0.000000	0.000000	31,975	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,714,329	0.000000	0.000000	344,626	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	631,541	0.000000	0.000000	279,264	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	6,843,795	0.000000	0.000000	1,459,878	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	0	11,054,865	0.000000	0.000000	20,670	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	490,035	0.000000	0.000000	0	92.00
200.00	Total (lines 50-199)	0	60,302,539			3,997,052	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151316

Period:
From 07/01/2012
To 06/30/2013

Worksheet D
Part IV
Date/Time Prepared:
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Cost Center Description			Title XVIII			Hospital		Cost
			Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
			11.00	12.00	13.00	21.00	22.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151316

Period:
From 07/01/2012
To 06/30/2013

Worksheet D
Part IV
Date/Time Prepared:
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Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	Title XVIII	Hospital	Cost
		23.00	24.00			
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0			50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0			52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0			54.00
60.00	06000 LABORATORY	0	0			60.00
65.00	06500 RESPIRATORY THERAPY	0	0			65.00
66.00	06600 PHYSICAL THERAPY	0	0			66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0			67.00
68.00	06800 SPEECH PATHOLOGY	0	0			68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0			73.00
OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	0	0			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0			92.00
200.00	Total (lines 50-199)	0	0			200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151316

Period:
From 07/01/2012
To 06/30/2013

Worksheet D
Part V
Date/Time Prepared:
11/26/2013 9:24 am

		Title XVIII		Hospital		Cost		
Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs			
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.267663	0	1,625,895	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.731038	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.151595	0	3,791,420	0	0	54.00
60.00	06000	LABORATORY	0.246764	0	3,105,413	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.402190	0	456,853	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.299584	0	986,321	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.280659	0	200,908	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.095499	0	26,087	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.133428	0	365,618	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.222621	0	43,664	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.199146	0	1,992,214	21,182	0	73.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0.323964	0	2,966,618	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.453390	0	166,922	0	0	92.00
200.00		Subtotal (see instructions)		0	15,727,933	21,182	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	15,727,933	21,182	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151316	Period: From 07/01/2012 To 06/30/2013	Worksheet D Part V Date/Time Prepared: 11/26/2013 9:24 am
Title XVIII		Hospital	Cost

Cost Center Description	Costs			Cost	
	Cost Reimbursed Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Subject To Ded. & Coins. (see inst.)			
	6.00	7.00			
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	435,192	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	574,760	0	54.00
60.00	06000	LABORATORY	766,304	0	60.00
65.00	06500	RESPIRATORY THERAPY	183,742	0	65.00
66.00	06600	PHYSICAL THERAPY	295,486	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	56,387	0	67.00
68.00	06800	SPEECH PATHOLOGY	28,578	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	48,784	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,721	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	396,741	4,218	73.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	961,077	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	242,603	0	92.00
200.00		Subtotal (see instructions)	3,999,375	4,218	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	3,999,375	4,218	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151316 Component CCN: 15Z316	Period: From 07/01/2012 To 06/30/2013	Worksheet D Part V Date/Time Prepared: 11/26/2013 9:24 am
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Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs			
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.267663	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.731038	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.151595	0	0	0	0	54.00
60.00	06000	LABORATORY	0.246764	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.402190	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.299584	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.280659	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.095499	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.133428	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.222621	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.199146	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0.323964	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.453390	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151316

Period:
From 07/01/2012
To 06/30/2013

Worksheet D
Part V
Date/Time Prepared:
11/26/2013 9:24 am

Component CCN: 152316

Title XVIII

Swing Beds - SNF

Cost

Cost Center Description	Costs			Cost	
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
	6.00	7.00			
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000	LABORATORY	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0	0	201.00
202.00		Net Charges (line 200 +/- line 201)	0	0	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 151316		Period: From 07/01/2012 To 06/30/2013		Worksheet D Part I Date/Time Prepared: 11/26/2013 9:24 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)	Hospital Total Patient Days	Cost 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	585,261	130,850	454,411	2,931	155.04	30.00
43.00	NURSERY	22,225		22,225	475	46.79	43.00
200.00	Total (lines 30-199)	607,486		476,636	3,406		200.00
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	48	7,442				
43.00	NURSERY	368	17,219				
200.00	Total (lines 30-199)	416	24,661				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 151316		Period: From 07/01/2012 To 06/30/2013		Worksheet D Part II Date/Time Prepared: 11/26/2013 9:24 am	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	Cost
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	233,104	7,467,677	0.031215	366,998	11,456	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	61,193	1,085,144	0.056392	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	180,745	13,679,839	0.013213	89,164	1,178	54.00
60.00	06000 LABORATORY	133,271	11,086,490	0.012021	231,405	2,782	60.00
65.00	06500 RESPIRATORY THERAPY	40,246	1,499,859	0.026833	35,035	940	65.00
66.00	06600 PHYSICAL THERAPY	75,490	3,585,721	0.021053	10,848	228	66.00
67.00	06700 OCCUPATIONAL THERAPY	10,818	1,011,358	0.010697	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	13,282	151,886	0.087447	0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	5,072	1,714,329	0.002959	57,859	171	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	3,117	631,541	0.004936	33,878	167	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	72,425	6,843,795	0.010583	412,403	4,364	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	207,981	11,054,865	0.018814	92,253	1,736	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	490,035	0.000000	0	0	92.00
200.00	Total (lines 50-199)	1,036,744	60,302,539		1,329,843	23,022	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 151316		Period: From 07/01/2012 To 06/30/2013		Worksheet D Part III Date/Time Prepared: 11/26/2013 9:24 am	
Cost Center Description			Title XIX			Hospital		Cost
			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. Nursing School	
			6.00	7.00	8.00	9.00	11.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,931	0.00	48	0	0	30.00
43.00	04300	NURSERY	475	0.00	368	0	0	43.00
200.00		Total (lines 30-199)	3,406		416	0	0	200.00
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	03000	ADULTS & PEDIATRICS	0	0				
43.00	04300	NURSERY	0	0				
200.00		Total (lines 30-199)	0	0				

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151316

Period:
From 07/01/2012
To 06/30/2013

Worksheet D
Part IV
Date/Time Prepared:
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Cost Center Description		Title XIX			Hospital	Cost	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	0 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0 52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0 54.00
60.00	06000	LABORATORY	0	0	0	0	0 60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0 65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0 68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0	0	0	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0 92.00
200.00		Total (lines 50-199)	0	0	0	0	0 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151316

Period:
From 07/01/2012
To 06/30/2013

Worksheet D
Part IV
Date/Time Prepared:
11/26/2013 9:24 am

Cost Center Description		Title XIX			Hospital		
		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	7,467,677	0.000000	0.000000	366,998	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	1,085,144	0.000000	0.000000	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	13,679,839	0.000000	0.000000	89,164	54.00
60.00	06000 LABORATORY	0	11,086,490	0.000000	0.000000	231,405	60.00
65.00	06500 RESPIRATORY THERAPY	0	1,499,859	0.000000	0.000000	35,035	65.00
66.00	06600 PHYSICAL THERAPY	0	3,585,721	0.000000	0.000000	10,848	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	1,011,358	0.000000	0.000000	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	151,886	0.000000	0.000000	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,714,329	0.000000	0.000000	57,859	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	631,541	0.000000	0.000000	33,878	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	6,843,795	0.000000	0.000000	412,403	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	0	11,054,865	0.000000	0.000000	92,253	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	490,035	0.000000	0.000000	0	92.00
200.00	Total (lines 50-199)	0	60,302,539			1,329,843	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151316

Period:
From 07/01/2012
To 06/30/2013

Worksheet D
Part IV
Date/Time Prepared:
11/26/2013 9:24 am

Cost Center Description		Title XIX			Hospital	Cost	
		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151316

Period:
From 07/01/2012
To 06/30/2013

Worksheet D
Part IV
Date/Time Prepared:
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Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	Cost
		23.00	24.00	
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000 LABORATORY	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
OUTPATIENT SERVICE COST CENTERS				
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00	Total (lines 50-199)	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151316	Period: From 07/01/2012 To 06/30/2013	Worksheet D-1 Date/Time Prepared: 11/26/2013 9:24 am
Cost Center Description		Title XVIII	Hospital	Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,838	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,931	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		2,380	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		422	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)		422	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		31	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)		32	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		1,328	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)		411	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)		411	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			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		126.36	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		126.36	20.00
21.00	Total general inpatient routine service cost (see instructions)		4,887,446	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		3,917	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)		4,044	25.00
26.00	Total swing-bed cost (see instructions)		1,098,899	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		3,788,547	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	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)		0.000000	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)		3,788,547	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)		1,292.58	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,716,546	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)		1,716,546	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151316	Period: From 07/01/2012 To 06/30/2013	Worksheet D-1 Date/Time Prepared: 11/26/2013 9:24 am
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Cost Center Description	Title XVIII			Hospital	Cost
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0
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)					966,374
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,682,920
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
51.00 Pass through costs applicable to Program inpatient ancillary services (from wkst. D, sum of Parts II and IV)					0
52.00 Total Program excludable cost (sum of lines 50 and 51)					0
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00 Program discharges					0
55.00 Target amount per discharge					0.00
56.00 Target amount (line 54 x line 55)					0
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00 Bonus payment (see instructions)					0
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
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
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
62.00 Relief payment (see instructions)					0
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0
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)					531,250
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					531,250
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					1,062,500
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
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
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
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)					551
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,292.58
89.00 Observation bed cost (line 87 x line 88) (see instructions)					712,212

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151316

Period:
From 07/01/2012
To 06/30/2013

Worksheet D-1

Date/Time Prepared:
11/26/2013 9:24 am

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

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151316	Period: From 07/01/2012 To 06/30/2013	Worksheet D-1 Date/Time Prepared: 11/26/2013 9:24 am
Cost Center Description		Title XIX	Hospital	Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			3,838 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			2,931 2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.			0 3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			2,380 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			422 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)			422 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			31 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)			32 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			48 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)			475 15.00
16.00	Nursery days (title V or XIX only)			368 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			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			0.00 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			0.00 20.00
21.00	Total general inpatient routine service cost (see instructions)			4,887,446 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)			1,092,718 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			3,794,728 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0 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)			0.000000 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)			3,794,728 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)			1,294.69 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			62,145 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)			62,145 41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151316

Period:
From 07/01/2012
To 06/30/2013

Worksheet D-1

Date/Time Prepared:
11/26/2013 9:24 am

Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	Cost
NURSERY (title V & XIX only)		394,120	475	829.73	368	305,341	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)					313,469	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					680,955	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)					551	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,294.69	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					713,374	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151316

Period:
From 07/01/2012
To 06/30/2013

Worksheet D-1

Date/Time Prepared:
11/26/2013 9:24 am

Cost Center Description	Title XIX		Hospital		Cost
	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: 151316	Period: From 07/01/2012 To 06/30/2013	Worksheet D-3 Date/Time Prepared: 11/26/2013 9:24 am	
Cost Center Description		Ratio of Cost To Charges	Hospital Inpatient Program Charges	Cost Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		1,196,940	30.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.267663	401,278	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.731038	3,534	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.151595	290,829	54.00
60.00	06000	LABORATORY	0.246764	428,091	60.00
65.00	06500	RESPIRATORY THERAPY	0.402190	461,893	65.00
66.00	06600	PHYSICAL THERAPY	0.299584	163,686	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.280659	111,328	67.00
68.00	06800	SPEECH PATHOLOGY	1.095499	31,975	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.133428	344,626	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.222621	279,264	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.199146	1,459,878	73.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.323964	20,670	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.453390	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		3,997,052	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net Charges (line 200 minus line 201)		3,997,052	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151316 Component CCN: 15Z316	Period: From 07/01/2012 To 06/30/2013	Worksheet D-3 Date/Time Prepared: 11/26/2013 9:24 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.267663	12,300	3,292 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.731038	0	0 52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.151595	40,031	6,068 54.00
60.00	06000	LABORATORY	0.246764	51,697	12,757 60.00
65.00	06500	RESPIRATORY THERAPY	0.402190	58,735	23,623 65.00
66.00	06600	PHYSICAL THERAPY	0.299584	459,901	137,779 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.280659	324,344	91,030 67.00
68.00	06800	SPEECH PATHOLOGY	1.095499	18,971	20,783 68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.133428	49,517	6,607 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.222621	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.199146	504,526	100,474 73.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.323964	204	66 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.453390	0	0 92.00
200.00		Total (sum of lines 50-94 and 96-98)		1,520,226	402,479 200.00
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)		1,520,226	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151316	Period: From 07/01/2012 To 06/30/2013	Worksheet D-3 Date/Time Prepared: 11/26/2013 9:24 am	
Cost Center Description		Ratio of Cost To Charges	Hospital Inpatient Program Charges	Cost Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		1,713,212	30.00
43.00	04300	NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.267663	366,998	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.731038	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.151595	89,164	54.00
60.00	06000	LABORATORY	0.246764	231,405	60.00
65.00	06500	RESPIRATORY THERAPY	0.402190	35,035	65.00
66.00	06600	PHYSICAL THERAPY	0.299584	10,848	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.280659	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.095499	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.133428	57,859	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.222621	33,878	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.199146	412,403	73.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.323964	92,253	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.453390	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		1,329,843	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net Charges (line 200 minus line 201)		1,329,843	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151316	Period: From 07/01/2012 To 06/30/2013	Worksheet E Part B Date/Time Prepared: 11/26/2013 9:24 am
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		4,003,593	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	PPS payments		0	3.00
4.00	Outlier payment (see instructions)		0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		4,003,593	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from worksheet D-4, Part III, line 69, col. 4)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR 413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)		4,043,629	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		0	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		32,806	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		2,505,510	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)		1,505,313	27.00
28.00	Direct graduate medical education payments (from worksheet E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from worksheet E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		1,505,313	30.00
31.00	Primary payer payments		580	31.00
32.00	Subtotal (line 30 minus line 31)		1,504,733	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)		458,231	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		458,231	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		345,016	36.00
37.00	Subtotal (see instructions)		1,962,964	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00			0	39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		1,962,964	40.00
40.01	Sequestration adjustment (see instructions)		9,815	40.01
41.00	Interim payments		2,159,643	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-206,494	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
				overrides
				1.00
WORKSHEET OVERRIDE VALUES				
112.00	Override of Ancillary service charges (line 12)			0 112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151316

Period:
From 07/01/2012
To 06/30/2013

Worksheet E-1
Part I
Date/Time Prepared:
11/26/2013 9:24 am

		Title XVIII		Hospital		Cost	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		2,112,796		2,030,443	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	01/03/2013	69,600	01/03/2013	129,200	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)		69,600		129,200	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to wkst. E or wkst. E-3, line and column as appropriate)		2,182,396		2,159,643	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		233,652		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		196,679	6.02	
7.00	Total Medicare program liability (see instructions)		2,416,048		1,962,964	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151316

Period: From 07/01/2012

Worksheet E-1

Component CCN: 152316

To 06/30/2013

Part I
Date/Time Prepared: 11/26/2013 9:24 am

		Title XVIII		Swing Beds - SNF		Cost	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		1,321,275		0	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER	01/03/2013	74,000		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)		74,000		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to wkst. E or wkst. E-3, line and column as appropriate)		1,395,275		0	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00	
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00	
6.01	SETTLEMENT TO PROVIDER		74,063		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		1,469,338		0	7.00	
		0		Contractor Number		NPR Date (Mo/Day/Yr)	
				1.00		2.00	
8.00	Name of Contractor					8.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 151316 Component CCN: 152316	Period: From 07/01/2012 To 06/30/2013	Worksheet E-2 Date/Time Prepared: 11/26/2013 9:24 am
		Title XVIII	Swing Beds - SNF	Cost
		Part A	Part B	
		1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)	1,073,125	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from wkst. D-3, column 3, line 200 for Part A, and sum of wkst. D, Part V, columns 5 and 7, line 202 for Part B) (For CAH, see instructions)	406,504	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	822	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	1,479,629	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,479,629	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	1,479,629	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	10,291	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	1,469,338	0	15.00
16.00		0	0	16.00
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	1,469,338	0	19.00
19.01	Sequestration adjustment (see instructions)	7,347	0	19.01
20.00	Interim payments	1,395,275	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program line 19 minus lines 19.01, 20 and 21	66,716	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151316	Period: From 07/01/2012 To 06/30/2013	Worksheet E-3 Part V Date/Time Prepared: 11/26/2013 9:24 am
		Title XVIII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)				
1.00	Inpatient services		2,682,920	1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction)		0	2.00
3.00	Organ acquisition		0	3.00
4.00	Subtotal (sum of lines 1 thru 3)		2,682,920	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		2,709,749	6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
7.00	Routine service charges		0	7.00
8.00	Ancillary service charges		0	8.00
9.00	Organ acquisition charges, net of revenue		0	9.00
10.00	Total reasonable charges		0	10.00
Customary charges				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)		0.000000	13.00
14.00	Total customary charges (see instructions)		0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)		0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)		0	16.00
17.00	Cost of teaching physicians (from worksheet D-5, Part II, column 3, line 20) (see instructions)		0	17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from worksheet E-4, line 49)		0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)		2,709,749	19.00
20.00	Deductibles (exclude professional component)		303,989	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20)		2,405,760	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		2,405,760	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		10,288	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		10,288	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		3,468	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		2,416,048	28.00
29.00			0	29.00
29.99	Recovery of Accelerated Depreciation		0	29.99
30.00	Subtotal (line 28, plus or minus lines 29)		2,416,048	30.00
30.01	Sequestration adjustment (see instructions)		12,080	30.01
31.00	Interim payments		2,182,396	31.00
32.00	Tentative settlement (for contractor use only)		0	32.00
33.00	Balance due provider/program line 30 minus lines 30.01, 31, and 32		221,572	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 151316

Period:
From 07/01/2012
To 06/30/2013

Worksheet E-3
Part VII
Date/Time Prepared:
11/26/2013 12:56 pm

		Title XIX		Hospital		Cost	
				Inpatient	Outpatient		
				1.00	2.00		
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			680,955			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)			680,955	0		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)			680,955	0		7.00
COMPUTATION OF LESSER OF COST OR CHARGES							
Reasonable Charges							
8.00	Routine service charges			0			8.00
9.00	Ancillary service charges			1,329,843	0		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)			1,329,843	0		12.00
CUSTOMARY CHARGES							
13.00	Amount actually collected from patients liable for payment for services on a charge basis			0	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	0		14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)			0.000000	0.000000		15.00
16.00	Total customary charges (see instructions)			1,329,843	0		16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)			648,888	0		17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)			0	0		18.00
19.00	Interns and Residents (see instructions)			0	0		19.00
20.00	Cost of Teaching Physicians (see instructions)			0	0		20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)			680,955	0		21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.							
22.00	Other than outlier payments			0	0		22.00
23.00	Outlier payments			0	0		23.00
24.00	Program capital payments			0	0		24.00
25.00	Capital exception payments (see instructions)			0	0		25.00
26.00	Routine and Ancillary service other pass through costs			0	0		26.00
27.00	Subtotal (sum of lines 22 through 26)			0	0		27.00
28.00	Customary charges (title V or XIX PPS covered services only)			0	0		28.00
29.00	Titles V or XIX (sum of lines 21 and 27)			680,955	0		29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT							
30.00	Excess of reasonable cost (from line 18)			0	0		30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)			680,955	0		31.00
32.00	Deductibles			0	0		32.00
33.00	Coinsurance			0	0		33.00
34.00	Allowable bad debts (see instructions)			0	0		34.00
35.00	Utilization review			0	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)			680,955	0		36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	0		37.00
38.00	Subtotal (line 36 ± line 37)			680,955	0		38.00
39.00	Direct graduate medical education payments (from wkst. E-4)			0	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)			680,955	0		40.00
41.00	Interim payments			680,955	0		41.00
42.00	Balance due provider/program (line 40 minus 41)			0	0		42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2			0	0		43.00

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

Provider CCN: 151316

Period:
From 07/01/2012
To 06/30/2013

Worksheet G

Date/Time Prepared:
11/26/2013 9:24 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	1,994,695	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	6,967,042	0	0	0	4.00
5.00	Other receivable	213,447	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-4,064,927	0	0	0	6.00
7.00	Inventory	422,974	0	0	0	7.00
8.00	Prepaid expenses	22,365	0	0	0	8.00
9.00	Other current assets	323,060	0	0	0	9.00
10.00	Due from other funds	-34,242	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	5,844,414	0	0	0	11.00
FIXED ASSETS						
12.00	Land	160,146	0	0	0	12.00
13.00	Land improvements	66,241	0	0	0	13.00
14.00	Accumulated depreciation	-31,464	0	0	0	14.00
15.00	Buildings	1,906,409	0	0	0	15.00
16.00	Accumulated depreciation	-700,128	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	758,364	0	0	0	19.00
20.00	Accumulated depreciation	-470,082	0	0	0	20.00
21.00	Automobiles and trucks	25,700	0	0	0	21.00
22.00	Accumulated depreciation	-20,774	0	0	0	22.00
23.00	Major movable equipment	6,119,162	0	0	0	23.00
24.00	Accumulated depreciation	-5,216,301	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	2,597,273	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	37,890,825	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	38,458	34,242	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	37,929,283	34,242	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	46,370,970	34,242	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	2,325,279	0	0	0	37.00
38.00	Salaries, wages, and fees payable	625,943	0	0	0	38.00
39.00	Payroll taxes payable	81,320	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	4,230,150	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	7,262,692	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	540,578	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	540,578	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	7,803,270	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	38,567,700				52.00
53.00	Specific purpose fund		34,242			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)	38,567,700	34,242	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	46,370,970	34,242	0	0	60.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 151316

Period:
From 07/01/2012
To 06/30/2013

Worksheet G-2
Parts I & II
Date/Time Prepared:
11/26/2013 9:24 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	5,832,724		5,832,724	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	5,832,724		5,832,724	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)	5,832,724		5,832,724	17.00
18.00	Ancillary services	8,983,101	38,689,395	47,672,496	18.00
19.00	Outpatient services	315,778	10,739,087	11,054,865	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	PHYSICIAN REVENUE	0	374,609	374,609	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to wkst. G-3, line 1)	15,131,603	49,803,091	64,934,694	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per wkst. A, column 3, line 200)		23,525,972		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to wkst. G-3, line 4)		23,525,972		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 151316	Period: From 07/01/2012 To 06/30/2013	Worksheet G-3 Date/Time Prepared: 11/26/2013 9:24 am
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		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	64,934,694	1.00
2.00	Less contractual allowances and discounts on patients' accounts	38,154,713	2.00
3.00	Net patient revenues (line 1 minus line 2)	26,779,981	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	23,525,972	4.00
5.00	Net income from service to patients (line 3 minus line 4)	3,254,009	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	1,559,955	7.00
8.00	Revenues from telephone and other miscellaneous communication services	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	106,031	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	10,814	17.00
18.00	Revenue from sale of medical records and abstracts	9,354	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	152,676	22.00
23.00	Governmental appropriations	0	23.00
24.00	NET ASSETS RELEASED FROM RESTRICTION	70,093	24.00
24.01	MISC INCOME	38,354	24.01
24.02	FOUNDATION	392,438	24.02
24.03	OTHER - UNREALIZED LOSSES	1,107,165	24.03
25.00	Total other income (sum of lines 6-24)	3,446,880	25.00
26.00	Total (line 5 plus line 25)	6,700,889	26.00
27.00	OTHER	48,147	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	48,147	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	6,652,742	29.00

CMS 339 Questionnaire - Exhibit 1
 Date Prepared: 11/14/2013 3:23:58 PM
 Data File: X:\HFSdata\clients\Hospital\St Vincent\Frankfort\28350-13.mcrx
 Fiscal Year: 07/01/2012 To 06/30/2013
 Provider Name: ST. VINCENT FRANKFORT HOSPITAL
 Provider No: 151316

Health Financial Systems
 MCRIF32

Allocation of Physician Compensation: Hours
Department: ADMINISTRATION
Physician: AGGREGATE ROUTINE PHYSICIANS
Provider: ST. VINCENT FRANKFORT HOSPITAL
Number: 151316
Specialty: INTERNAL MEDICINE-GENERAL

Basis of Allocation: Time Study **Describe:**

Services	Total Hours
1. Provider Services - Teaching and Supervision of I/R's and other GME Related Functions.	0.00
1A. Provider Services - Teaching and Supervision of Allied Health Students.	0.00
1B. Provider Services - Non Teaching Reimbursable Activities such as Department Administration, Supervision of Nursing, and Technical Staff, Utilization Review, etc.	0.00
1C. Provider Services - Emergency Room Physician Availability (Do not include minimum guarantee arrangements for Emergency Room Physicians.)	0.00
1D. Sub-Total - Provider Administrative Services (Lines 1, 1A, 1B, 1C.)	0.00
2. Physician Services: Medical and Surgical Services to Individual Patients.	2080.00
3. Non-Reimbursable Activities: Research, Teaching of I/R's in Non-Approved Programs, Teaching and Supervision of Medical Students, Writing for Medical Journals, etc.	0.00
4. Total Hours (Lines 1D, 2, and 3)	2080.00
5. Professional Component Percentage (Line 2 / Line 4)	100.00 %
6. Provider Component Percentage - (Line 1D / Line 4)	0.00 %

Signature: Physician or Physician Department Head

Date

v7

CMS 339 Questionnaire - Exhibit 1
 Date Prepared: 11/14/2013 3:24:06 PM
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 Fiscal Year: 07/01/2012 To 06/30/2013
 Provider Name: ST. VINCENT FRANKFORT HOSPITAL
 Provider No: 151316

Health Financial Systems
 MCRIF32

Allocation of Physician Compensation: Hours
Department: ADMINISTRATION
Physician: AGGREGATE ADULTS & PEDS PHYSICIANS
Provider: ST. VINCENT FRANKFORT HOSPITAL
Number: 151316
Specialty: INTERNAL MEDICINE & PEDIATRICS-GE

Basis of Allocation: Time Study **Describe:**

Services	Total Hours
1. Provider Services - Teaching and Supervision of I/R's and other GME Related Functions.	0.00
1A. Provider Services - Teaching and Supervision of Allied Health Students.	0.00
1B. Provider Services - Non Teaching Reimbursable Activities such as Department Administration, Supervision of Nursing, and Technical Staff, Utilization Review, etc.	0.00
1C. Provider Services - Emergency Room Physician Availability (Do not include minimum guarantee arrangements for Emergency Room Physicians.)	0.00
1D. Sub-Total - Provider Administrative Services (Lines 1, 1A, 1B, 1C.)	0.00
2. Physician Services: Medical and Surgical Services to Individual Patients.	2080.00
3. Non-Reimbursable Activities: Research, Teaching of I/R's in Non-Approved Programs, Teaching and Supervision of Medical Students, Writing for Medical Journals, etc.	0.00
4. Total Hours (Lines 1D, 2, and 3)	2080.00
5. Professional Component Percentage (Line 2 / Line 4)	100.00 %
6. Provider Component Percentage - (Line 1D / Line 4)	0.00 %

 Signature: Physician or Physician Department Head

 Date

v7

CMS 339 Questionnaire - Exhibit 1
 Date Prepared: 11/14/2013 3:24:15 PM
 Data File: X:\HFSdata\clients\Hospital\St Vincent\Frankfort\28350-13.mcrx
 Fiscal Year: 07/01/2012 To 06/30/2013
 Provider Name: ST. VINCENT FRANKFORT HOSPITAL
 Provider No: 151316

Health Financial Systems
 MCRIF32

Allocation of Physician Compensation: Hours
Department: SURGERY **Provider:** ST. VINCENT FRANKFORT HOSPITAL
Physician: AGGREGATE OPERATING ROOM PHYSICIANS **Number:** 151316
Specialty: SURGERY-GENERAL

Basis of Allocation: Time Study **Describe:**

Services	Total Hours
1. Provider Services - Teaching and Supervision of I/R's and other GME Related Functions.	0.00
1A. Provider Services - Teaching and Supervision of Allied Health Students.	0.00
1B. Provider Services - Non Teaching Reimbursable Activities such as Department Administration, Supervision of Nursing, and Technical Staff, Utilization Review, etc.	0.00
1C. Provider Services - Emergency Room Physician Availability (Do not include minimum guarantee arrangements for Emergency Room Physicians.)	0.00
1D. Sub-Total - Provider Administrative Services (Lines 1, 1A, 1B, 1C.)	0.00
2. Physician Services: Medical and Surgical Services to Individual Patients.	2080.00
3. Non-Reimbursable Activities: Research, Teaching of I/R's in Non-Approved Programs, Teaching and Supervision of Medical Students, Writing for Medical Journals, etc.	0.00
4. Total Hours (Lines 1D, 2, and 3)	2080.00
5. Professional Component Percentage (Line 2 / Line 4)	100.00 %
6. Provider Component Percentage - (Line 1D / Line 4)	0.00 %

Signature: Physician or Physician Department Head

Date

v7

Date Prepared: 11/14/2013 3:24:22 PM

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Fiscal Year: 07/01/2012 To 06/30/2013

Provider Name: ST. VINCENT FRANKFORT HOSPITAL

Health Financial Systems

Provider No: 151316

MCRIF32

Allocation of Physician Compensation: Hours

Department: REHABILITATION SERVICES

Provider: ST. VINCENT FRANKFORT HOSPITAL

Physician: AGGREGATE PHYSICAL THERAPY PHYSICIANS

Number: 151316

Specialty: PHYSICAL MEDICINE/REHABILITATION-

Basis of Allocation: Time Study

Describe:

Services	Total Hours
1. Provider Services - Teaching and Supervision of I/R's and other GME Related Functions.	0.00
1A. Provider Services - Teaching and Supervision of Allied Health Students.	0.00
1B. Provider Services - Non Teaching Reimbursable Activities such as Department Administration, Supervision of Nursing, and Technical Staff, Utilization Review, etc.	0.00
1C. Provider Services - Emergency Room Physician Availability (Do not include minimum guarantee arrangements for Emergency Room Physicians.)	0.00
1D. Sub-Total - Provider Administrative Services (Lines 1, 1A, 1B, 1C.)	0.00
2. Physician Services: Medical and Surgical Services to Individual Patients.	2080.00
3. Non-Reimbursable Activities: Research, Teaching of I/R's in Non-Approved Programs, Teaching and Supervision of Medical Students, Writing for Medical Journals, etc.	0.00
4. Total Hours (Lines 1D, 2, and 3)	2080.00
5. Professional Component Percentage (Line 2 / Line 4)	100.00 %
6. Provider Component Percentage - (Line 1D / Line 4)	0.00 %

Signature: Physician or Physician Department Head

Date

v7

CMS 339 Questionnaire - Exhibit 1
 Date Prepared: 11/22/2013 2:41:57 PM
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 Fiscal Year: 07/01/2012 To 06/30/2013
 Provider Name: ST. VINCENT FRANKFORT HOSPITAL
 Provider No: 151316

Health Financial Systems
 MCRIF32

Allocation of Physician Compensation: Hours
Department: EMERGENCY DEPARTMENT
Physician: AGGREGATE EMERGENCY PHYSICIANS
Provider: ST. VINCENT FRANKFORT HOSPITAL
Number: 151316
Specialty: EMERGENCY MEDICINE-GENERAL

Basis of Allocation: Time Study **Describe:**

Services	Total Hours
1. Provider Services - Teaching and Supervision of I/R's and other GME Related Functions.	0.00
1A. Provider Services - Teaching and Supervision of Allied Health Students.	0.00
1B. Provider Services - Non Teaching Reimbursable Activities such as Department Administration, Supervision of Nursing, and Technical Staff, Utilization Review, etc.	0.00
1C. Provider Services - Emergency Room Physician Availability (Do not include minimum guarantee arrangements for Emergency Room Physicians.)	7662.00
1D. Sub-Total - Provider Administrative Services (Lines 1, 1A, 1B, 1C.)	7662.00
2. Physician Services: Medical and Surgical Services to Individual Patients.	1098.00
3. Non-Reimbursable Activities: Research, Teaching of I/R's in Non-Approved Programs, Teaching and Supervision of Medical Students, Writing for Medical Journals, etc.	0.00
4. Total Hours (Lines 1D, 2, and 3)	8760.00
5. Professional Component Percentage (Line 2 / Line 4)	12.53 %
6. Provider Component Percentage - (Line 1D / Line 4)	87.47 %

Signature: Physician or Physician Department Head

Date

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CMS 339 Questionnaire - Exhibit 1
 Date Prepared: 11/26/2013 10:16:46 AM
 Data File: X:\HFSdata\clients\Hospital\St Vincent\Frankfort\28350-13.mcrx
 Fiscal Year: 07/01/2012 To 06/30/2013
 Provider Name: ST. VINCENT FRANKFORT HOSPITAL
 Provider No: 151316

Health Financial Systems
 MCRIF32

Allocation of Physician Compensation: Hours	Provider:	ST. VINCENT FRANKFORT HOSPITAL
Department: RADIOLOGY	Number:	151316
Physician: AGGREGATE RADIOLOGY PHYSICIAN	Specialty:	RADIOLOGY-GENERAL

Basis of Allocation: Time Study **Describe:**

Services	Total Hours
1. Provider Services - Teaching and Supervision of I/R's and other GME Related Functions.	0.00
1A. Provider Services - Teaching and Supervision of Allied Health Students.	0.00
1B. Provider Services - Non Teaching Reimbursable Activities such as Department Administration, Supervision of Nursing, and Technical Staff, Utilization Review, etc.	0.00
1C. Provider Services - Emergency Room Physician Availability (Do not include minimum guarantee arrangements for Emergency Room Physicians.)	0.00
1D. Sub-Total - Provider Administrative Services (Lines 1, 1A, 1B, 1C.)	0.00
2. Physician Services: Medical and Surgical Services to Individual Patients.	2080.00
3. Non-Reimbursable Activities: Research, Teaching of I/R's in Non-Approved Programs, Teaching and Supervision of Medical Students, Writing for Medical Journals, etc.	0.00
4. Total Hours (Lines 1D, 2, and 3)	2080.00
5. Professional Component Percentage (Line 2 / Line 4)	100.00 %
6. Provider Component Percentage - (Line 1D / Line 4)	0.00 %

 Signature: Physician or Physician Department Head

 Date

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