

St. Vincent Heart Center of Indiana

Provider No. 15-0153 and AIM No. 200398730

**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: 150153	Period: From 07/01/2012 To 06/30/2013	Worksheet 5 Parts I-III Date/Time Prepared: 11/26/2013 2:31 pm
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PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 11/26/2013 Time: 2:31 pm
Contractor use only	5. <input type="checkbox"/> 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. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN
		10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above 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 HEART CENTER (150153) 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: 2:31 pm
leKiQ2Zox7hTqoEy3hjCTHng8TNJ10
Qs7ts01w3AjZFiwrRdpndeHADL9aw
7sji0J4kkq0YPHto
PI: Date: 11/26/2013 Time: 2:31 pm
kYN:T:WXBkGodSeLDizyx.:10FTHA0
MeD0B0L3b8nksY1uOCBmVOA.UdZBeF
tc190DETPG0h4904

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

Title

Date

	Title v	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	-17,730	50,840	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	0	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
200.00 Total	0	-17,730	50,840	0	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150153	Period: From 07/01/2012 To 06/30/2013	Worksheet S-2 Part I Date/Time Prepared: 11/26/2013 9:54 am
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1.00	2.00	3.00	4.00
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Hospital and Hospital Health Care Complex Address:				
1.00	Street: 10580 N. MERIDIAN ST.	PO Box:		1.00
2.00	City: INDIANAPOLIS	State: IN	Zip Code: 46290	2.00
			County: HAMILTON	

	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 HEART CENTER	150153	26900	1	12/05/2002	N	P	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									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)	4		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.	3	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.	491	0	0	0	276	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.	1		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.	1		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150153	Period: From 07/01/2012 To 06/30/2013	Worksheet S-2 Part I Date/Time Prepared: 11/26/2013 9:54 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)				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	Y	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.				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: 150153	Period: From 07/01/2012 To 06/30/2013	Worksheet S-2 Part I Date/Time Prepared: 11/26/2013 9:54 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
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.					
64.00	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
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))
			1.00	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
Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010					
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000 66.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 150153

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

Worksheet S-2
Part I
Date/Time Prepared:
11/26/2013 9:54 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	
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		N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.						N	92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.				N		N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.				N		N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.					0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.				N		N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.					0.00	0.00	97.00
Rural Providers								
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?				N			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)							106.00

		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)					107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N				108.00
		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					109.00
				1.00	2.00	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:	29,494	0			118.01
				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		15H046	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150153	Period: From 07/01/2012 To 06/30/2013	Worksheet S-2 Part I Date/Time Prepared: 11/26/2013 9:54 am
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		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: 08101			141.00	
142.00	Street: 10330 N. MERIDIAN ST	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.						Y	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	
Multicampus								
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00	166.00
							1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act								
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.						N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						0.00	168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.00	169.00
							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)							170.00

		Y/N	Date	
		1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N	Date	V/I
		1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y		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
		Part A		Part B
Description		Y/N	Date	Y/N
0		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.	NANCY		GAYLE	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) 583-3236		NKGAYLE@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.	MANAGER		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: 150153

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

Worksheet S-2
Part IX
Date/Time Prepared:
11/26/2013 9:54 am

		Title V	Title XIX	
		1.00	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	Outpatient	
		1.00	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	Title XIX	
		1.00	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: 150153

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

Worksheet S-3
Part I
Date/Time Prepared:
11/26/2013 9:54 am

Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	I/P Days / O/P	Title V
	Line Number		Available		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	107	39,055	0.00	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)		107	39,055	0.00	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						13.00
14.00 Total (see instructions)		107	39,055	0.00	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)		107				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)	11,871	491	20,988			1.00
2.00 HMO and other (see instructions)	2,320	276				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	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0	0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	11,871	491	20,988			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)	11,871	491	20,988	0.00	461.96	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
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	461.96	27.00
28.00 Observation Bed Days		0	1,698			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
33.00 LTCH non-covered days	0					33.00

Component	Full Time	Discharges			Total All Patients	
	Equivalents	Title V	Title XVIII	Title XIX		
	Nonpaid Workers	12.00	13.00	14.00		
	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	2,708	180	5,210	1.00
2.00 HMO and other (see instructions)			551			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	2,708	180	5,210	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

	Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	31,383,847	0	31,383,847	960,876.00	32.66
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office personnel		10,822	0	10,822	282.00	38.38
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		0	0	0	0.00	0.00
OTHER WAGES & RELATED COSTS							
11.00	Contract labor (see instructions)		407,957	0	407,957	5,798.00	70.36
12.00	Contract management and administrative services		0	0	0	0.00	0.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00
14.00	Home office salaries & wage-related costs		5,572,355	0	5,572,355	121,738.00	45.77
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		8,886,834	0	8,886,834		
18.00	Wage-related costs (other) (see instructions)		0	0	0		
19.00	Excluded areas		0	0	0		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	577,815	0	577,815	7,680.00	75.24
27.00	Administrative & General	5.00	4,414,448	0	4,414,448	155,923.00	28.31
28.00	Administrative & General under contract (see inst.)		127,865	0	127,865	4,119.00	31.04
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00
30.00	Operation of Plant	7.00	547,196	0	547,196	21,050.00	26.00
31.00	Laundry & Linen Service	8.00	30,903	0	30,903	2,585.00	11.95
32.00	Housekeeping	9.00	0	0	0	0.00	0.00
33.00	Housekeeping under contract (see instructions)		700,750	0	700,750	39,658.00	17.67
34.00	Dietary	10.00	0	0	0	0.00	0.00
35.00	Dietary under contract (see instructions)		1,223,248	0	1,223,248	70,708.00	17.30
36.00	Cafeteria	11.00	0	0	0	0.00	0.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00
38.00	Nursing Administration	13.00	1,055,122	0	1,055,122	24,379.00	43.28
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00
40.00	Pharmacy	15.00	1,967,556	0	1,967,556	42,887.00	45.88
41.00	Medical Records & Medical Records Library	16.00	468,196	0	468,196	19,468.00	24.05

Provider CCN: 150153

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

Worksheet S-3
Part II
Date/Time Prepared:
11/26/2013 9:54 am

	Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
42.00	Social Service	17.00	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0.00	0.00	43.00

Provider CCN: 150153

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

Worksheet S-3
Part III
Date/Time Prepared:
11/26/2013 9:54 am

	Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	33,424,888	0	33,424,888	1,075,079.00	31.09	1.00
2.00	Excluded area salaries (see instructions)	0	0	0	0.00	0.00	2.00
3.00	Subtotal salaries (line 1 minus line 2)	33,424,888	0	33,424,888	1,075,079.00	31.09	3.00
4.00	Subtotal other wages & related costs (see inst.)	5,980,312	0	5,980,312	127,536.00	46.89	4.00
5.00	Subtotal wage-related costs (see inst.)	8,886,834	0	8,886,834	0.00	26.59	5.00
6.00	Total (sum of lines 3 thru 5)	48,292,034	0	48,292,034	1,202,615.00	40.16	6.00
7.00	Total overhead cost (see instructions)	11,113,099	0	11,113,099	388,457.00	28.61	7.00

Provider CCN: 150153

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

Worksheet S-3
Part IV
Date/Time Prepared:
11/26/2013 9:54 am

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401k Employer Contributions	1,549,104	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401k/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	166	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	3,941,123	8.00
9.00	Prescription Drug Plan	603,763	9.00
10.00	Dental, Hearing and Vision Plan	47,396	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	23,015	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	81,210	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	38,980	14.00
15.00	'Workers' Compensation Insurance	234,561	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
TAXES			
17.00	FICA-Employers Portion Only	2,201,137	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	136,269	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	30,111	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	8,886,835	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 150153

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

Worksheet S-3
Part V
Date/Time Prepared:
11/26/2013 9:54 am

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	407,957	8,886,834	1.00
2.00	Hospital	407,957	8,886,834	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 150153	Period: From 07/01/2012 To 06/30/2013	Worksheet S-10 Date/Time Prepared: 11/26/2013 9:54 am
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			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)		0.229192	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		899,394	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		N	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?			4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		0	5.00
6.00	Medicaid charges		15,246,241	6.00
7.00	Medicaid cost (line 1 times line 6)		3,494,316	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)		2,594,922	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		18,332	18.00
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		2,594,922	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	10,893,479	49,759	10,943,238
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	2,496,698	11,404	2,508,102
22.00	Partial payment by patients approved for charity care	0	0	0
23.00	Cost of charity care (line 21 minus line 22)	2,496,698	11,404	2,508,102
				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)		1,485,236	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		162,328	27.00
28.00	Non-Medicare and Non-Reimbursable Medicare bad debt expense (line 26 minus line 27)		1,322,908	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		303,200	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)		2,811,302	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		5,406,224	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150153

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

Worksheet A

Date/Time Prepared:
11/26/2013 9:54 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		2,800,939	2,800,939	1,664,465	4,465,404	1.00
2.00	00200		2,950,302	2,950,302	438,219	3,388,521	2.00
4.00	00400	577,815	9,215,529	9,793,344	0	9,793,344	4.00
5.00	00500	4,414,448	17,624,377	22,038,825	-2,102,684	19,936,141	5.00
7.00	00700	547,196	3,386,574	3,933,770	0	3,933,770	7.00
8.00	00800	30,903	420,467	451,370	0	451,370	8.00
9.00	00900	0	849,000	849,000	0	849,000	9.00
10.00	01000	0	1,748,825	1,748,825	-1,326,234	422,591	10.00
11.00	01100	0	0	0	1,326,234	1,326,234	11.00
13.00	01300	1,055,122	134,637	1,189,759	0	1,189,759	13.00
15.00	01500	1,967,556	-47,940	1,919,616	0	1,919,616	15.00
16.00	01600	468,196	2,238,935	2,707,131	0	2,707,131	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	13,060,767	568,800	13,629,567	0	13,629,567	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	3,414,318	741,591	4,155,909	0	4,155,909	50.00
54.00	05400	1,064,260	706,760	1,771,020	0	1,771,020	54.00
59.00	05900	1,845,339	506,420	2,351,759	0	2,351,759	59.00
60.00	06000	0	3,018,597	3,018,597	0	3,018,597	60.00
65.00	06500	1,347,001	65,350	1,412,351	0	1,412,351	65.00
66.00	06600	280,171	6,175	286,346	0	286,346	66.00
71.00	07100	0	11,074,877	11,074,877	0	11,074,877	71.00
72.00	07200	0	14,745,687	14,745,687	0	14,745,687	72.00
73.00	07300	0	2,919,852	2,919,852	0	2,919,852	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	1,310,755	847,666	2,158,421	0	2,158,421	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
118.00		31,383,847	76,523,420	107,907,267	0	107,907,267	118.00
NONREIMBURSABLE COST CENTERS							
193.00	19300	0	0	0	0	0	193.00
193.01	19301	0	949,200	949,200	0	949,200	193.01
200.00		31,383,847	77,472,620	108,856,467	0	108,856,467	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150153

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

Worksheet A

Date/Time Prepared:
11/26/2013 9:54 am

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation		
		6.00	7.00		
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-1,769,661	2,695,743	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,336,688	4,725,209	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	987,751	10,781,095	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-6,121,543	13,814,598	5.00
7.00	00700	OPERATION OF PLANT	28	3,933,798	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	451,370	8.00
9.00	00900	HOUSEKEEPING	0	849,000	9.00
10.00	01000	DIETARY	0	422,591	10.00
11.00	01100	CAFETERIA	-508,822	817,412	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,189,759	13.00
15.00	01500	PHARMACY	0	1,919,616	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	206,801	2,913,932	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	13,629,567	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-880,031	3,275,878	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-91,907	1,679,113	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	2,351,759	59.00
60.00	06000	LABORATORY	0	3,018,597	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,412,351	65.00
66.00	06600	PHYSICAL THERAPY	0	286,346	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	11,074,877	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	14,745,687	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,919,852	73.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	-810,389	1,348,032	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	-7,651,085	100,256,182	118.00
NONREIMBURSABLE COST CENTERS					
193.00	19300	NONPAID WORKERS	0	0	193.00
193.01	19301	MARKETING	2,364,544	3,313,744	193.01
200.00		TOTAL (SUM OF LINES 118-199)	-5,286,541	103,569,926	200.00

COST CENTERS USED IN COST REPORT

Provider CCN: 150153

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

Worksheet Non-CMS W
Date/Time Prepared:
11/26/2013 9:54 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
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
13.00	NURSING ADMINISTRATION	01300		13.00
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
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	05000		50.00
54.00	RADIOLOGY-DIAGNOSTIC	05400		54.00
59.00	CARDIAC CATHETERIZATION	05900		59.00
60.00	LABORATORY	06000		60.00
65.00	RESPIRATORY THERAPY	06500		65.00
66.00	PHYSICAL THERAPY	06600		66.00
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				
193.00	NONPAID WORKERS	19300		193.00
193.01	MARKETING	19301		193.01
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 - CAPITAL					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,435,273	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	356,778	2.00
3.00	CAP REL COSTS-BLDG & FIXT	1.00	0	42,561	3.00
4.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	15,150	4.00
5.00	CAP REL COSTS-BLDG & FIXT	1.00	0	186,631	5.00
6.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	66,291	6.00
	TOTALS		0	2,102,684	
B - CAFETERIA					
1.00	CAFETERIA	11.00	0	1,326,234	1.00
	TOTALS		0	1,326,234	
500.00	Grand Total: Increases		0	3,428,918	500.00

Decreases							
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAPITAL						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,435,273	11	1.00	
2.00	ADMINISTRATIVE & GENERAL	5.00	0	356,778	11	2.00	
3.00	ADMINISTRATIVE & GENERAL	5.00	0	42,561	12	3.00	
4.00	ADMINISTRATIVE & GENERAL	5.00	0	15,150	12	4.00	
5.00	ADMINISTRATIVE & GENERAL	5.00	0	186,631	13	5.00	
6.00	ADMINISTRATIVE & GENERAL	5.00	0	66,291	13	6.00	
	TOTALS		0	2,102,684			
	B - CAFETERIA						
1.00	DIETARY	10.00	0	1,326,234	0	1.00	
	TOTALS		0	1,326,234			
500.00	Grand Total: Decreases		0	3,428,918		500.00	

Increases			Decreases			
Cost Center	Line #	Salary	Cost Center	Line #	Salary	
2.00	3.00	4.00	6.00	7.00	8.00	
A - CAPITAL						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	ADMINISTRATIVE & GENERAL	5.00	0 1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	ADMINISTRATIVE & GENERAL	5.00	0 2.00
3.00	CAP REL COSTS-BLDG & FIXT	1.00	0	ADMINISTRATIVE & GENERAL	5.00	0 3.00
4.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	ADMINISTRATIVE & GENERAL	5.00	0 4.00
5.00	CAP REL COSTS-BLDG & FIXT	1.00	0	ADMINISTRATIVE & GENERAL	5.00	0 5.00
6.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	ADMINISTRATIVE & GENERAL	5.00	0 6.00
	TOTALS		0	TOTALS		0
B - CAFETERIA						
1.00	CAFETERIA	11.00	0	DIETARY	10.00	0 1.00
	TOTALS		0	TOTALS		0
500.00	Grand Total: Increases		0	Grand Total: Decreases		0 500.00

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
		1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	2.00
3.00	Buildings and Fixtures	42,216,802	84,339	0	84,339	3.00
4.00	Building Improvements	0	0	0	0	4.00
5.00	Fixed Equipment	6,932,055	0	0	0	5.00
6.00	Movable Equipment	17,264,847	16,710	0	16,710	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	66,413,704	101,049	0	101,049	8.00
9.00	Reconciling Items	256,276	0	0	0	9.00
10.00	Total (line 8 minus line 9)	66,157,428	101,049	0	101,049	10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0			1.00
2.00	Land Improvements	0	0			2.00
3.00	Buildings and Fixtures	42,301,141	0			3.00
4.00	Building Improvements	0	0			4.00
5.00	Fixed Equipment	6,258,340	0			5.00
6.00	Movable Equipment	17,281,557	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	65,841,038	0			8.00
9.00	Reconciling Items	54,521	0			9.00
10.00	Total (line 8 minus line 9)	65,786,517	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150153

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

Worksheet A-7
Part II
Date/Time Prepared:
11/26/2013 9:54 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	2,140,099	660,840	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,699,049	1,251,253	0	0	0	2.00
3.00	Total (sum of lines 1-2)	3,839,148	1,912,093	0	0	0	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	2,800,939				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,950,302				2.00
3.00	Total (sum of lines 1-2)	0	5,751,241				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS	Provider CCN: 150153	Period: From 07/01/2012 To 06/30/2013	Worksheet A-7 Part III Date/Time Prepared: 11/26/2013 9:54 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	48,559,481	0	48,559,481	0.737901	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	17,248,137	0	17,248,137	0.262099	0	2.00
3.00	Total (sum of lines 1-2)	65,807,618	0	65,807,618	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	2,140,099	119,399	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	3,196,972	1,251,253	2.00
3.00	Total (sum of lines 1-2)	0	0	0	5,337,071	1,370,652	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	207,053	42,561	186,631	0	2,695,743	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	195,543	15,150	66,291	0	4,725,209	2.00
3.00	Total (sum of lines 1-2)	402,596	57,711	252,922	0	7,420,952	3.00

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on worksheet A To/From which the Amount is to be Adjusted				Ref.
			Cost Center		Line #	wkst. A-7	
			1.00	2.00	3.00	4.00	
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-648,629	CAP REL COSTS-BLDG & FIXT		1.00	11	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-161,235	CAP REL COSTS-MVBLE EQUIP		2.00	11	2.00
3.00 Investment income - other (chapter 2)	B	-110,122	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)		0			0.00	0	7.00
8.00 Television and radio service (chapter 21)		0			0.00	0	8.00
9.00 Parking lot (chapter 21)		0			0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-1,782,327				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	1,892,430				0	12.00
13.00 Laundry and linen service		0			0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-508,822	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		0			0.00	0	17.00
18.00 Sale of medical records and abstracts	B	-12,939	MEDICAL RECORDS & LIBRARY		16.00	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	0	*** Cost Center Deleted ***		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	*** Cost Center Deleted ***		68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0			0.00	0	32.00
33.00 SPONSORSHIPS/DONATIONS	A	-31,267	ADMINISTRATIVE & GENERAL		5.00	0	33.00
33.01 OTHER NON-REIMBURSABLE EXPENSE	A	-227	ADMINISTRATIVE & GENERAL		5.00	0	33.01

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Provider CCN: 150153

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

Worksheet A-8

Date/Time Prepared:
11/26/2013 9:54 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 LOBBYIST	A	-45,833	ADMINISTRATIVE & GENERAL	5.00	0 33.02
33.03 LOBBYING DUES	A	-1,344	ADMINISTRATIVE & GENERAL	5.00	0 33.03
33.04 MISCELLANEOUS INCOME	B	-40,229	ADMINISTRATIVE & GENERAL	5.00	0 33.04
33.05 PROVIDER ASSESSMENT TAX	A	-3,835,997	ADMINISTRATIVE & GENERAL	5.00	0 33.05
33.06		0		0.00	0 33.06
33.07		0		0.00	0 33.07
33.08		0		0.00	0 33.08
33.09		0		0.00	0 33.09
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200.)		-5,286,541			50.00

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

Provider CCN: 150153

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

Worksheet A-8-1

Date/Time Prepared:
11/26/2013 9:54 am

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	0.00		0	0	1.00
2.00	0.00		0	0	2.00
3.00	4.00	EMPLOYEE BENEFITS	606,209	606,209	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	3,180,056	5,150,496	4.00
4.01	7.00	OPERATION OF PLANT	64,896	64,896	4.01
4.02	13.00	NURSING ADMINISTRATION	-206,594	-206,594	4.02
4.03	15.00	PHARMACY	20,183	20,183	4.03
4.04	16.00	MEDICAL RECORDS & LIBRARY	1,895,914	1,895,914	4.04
4.05	30.00	ADULTS & PEDIATRICS	-52,758	-52,758	4.05
4.06	50.00	OPERATING ROOM	1,901,969	1,901,969	4.06
4.07	54.00	RADIOLOGY-DIAGNOSTIC	554,728	554,728	4.07
4.08	65.00	RESPIRATORY THERAPY	103,395	103,395	4.08
4.09	66.00	PHYSICAL THERAPY	179,094	179,094	4.09
4.10	193.01	MARKETING	927,585	927,585	4.10
4.11	59.00	CARDIAC CATHETERIZATION	-98,688	-98,688	4.11
4.12	91.00	EMERGENCY	-23,668	-23,668	4.12
4.13	0.00		0	0	4.13
4.14	4.00	EMPLOYEE BENEFITS	1,437,587	1,437,587	4.14
4.15	0.00		0	0	4.15
4.16	2.00	CAP REL COSTS-MVBLE EQUIP	1,497,923	0	4.16
4.17	4.00	EMPLOYEE BENEFITS	1,457,417	3,310	4.17
4.18	5.00	ADMINISTRATIVE & GENERAL	49,726	49,726	4.18
4.19	16.00	MEDICAL RECORDS & LIBRARY	219,740	0	4.19
4.20	193.01	MARKETING	2,364,544	0	4.20
4.21	7.00	OPERATION OF PLANT	1,994	1,966	4.21
4.22	5.00	ADMINISTRATIVE & GENERAL	118,552	204,636	4.22
4.23	1.00	CAP REL COSTS-BLDG & FIXT	798,199	1,377,790	4.23
4.24	4.00	EMPLOYEE BENEFITS	1,776,538	2,242,894	4.24
4.25	1.00	CAP REL COSTS-BLDG & FIXT	39,196	580,637	4.25
4.26	1.00	CAP REL COSTS-BLDG & FIXT	1,435,188	1,435,188	4.26
4.27	2.00	CAP REL COSTS-MVBLE EQUIP	356,863	356,863	4.27
4.28	4.00	EMPLOYEE BENEFITS	745,369	745,369	4.28
4.29	5.00	ADMINISTRATIVE & GENERAL	6,408,761	6,408,761	4.29
4.30	13.00	NURSING ADMINISTRATION	251,589	251,589	4.30
4.31	15.00	PHARMACY	-899	-899	4.31
4.32	16.00	MEDICAL RECORDS & LIBRARY	-12	-12	4.32
4.33	30.00	ADULTS & PEDIATRICS	52,913	52,913	4.33
4.34	50.00	OPERATING ROOM	-132	-132	4.34
4.35	54.00	RADIOLOGY-DIAGNOSTIC	3,258	3,258	4.35
4.36	59.00	CARDIAC CATHETERIZATION	98,688	98,688	4.36
4.37	65.00	RESPIRATORY THERAPY	12,127	12,127	4.37
4.38	91.00	EMERGENCY	23,668	23,668	4.38
4.39	193.01	MARKETING	21,615	21,615	4.39
4.40	0.00		0	0	4.40
4.41	0.00		0	0	4.41
5.00	0		28,222,733	26,330,303	5.00

* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to worksheet A, column 6, lines as appropriate.

Positive amounts increase cost and negative amounts decrease cost.

For related organization or home office cost which has not been posted to worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

Symbol (1)	Name	Percentage of Ownership	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	B	0.00	ST. VINCENT HOS	0.00	6.00
7.00	B	74.08	ST. VINCENT HEA	0.00	7.00
8.00	B	0.00	CIHS NEWCO	0.00	8.00

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

Provider CCN: 150153

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

Worksheet A-8-1

Date/Time Prepared:
11/26/2013 9:54 am

	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
9.00	B		100.00	ASCENSION	0.00
10.00			0.00		0.00
100.00	G. Other (financial or non-financial) specify:				
					9.00
					10.00
					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.

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

Provider CCN: 150153

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

Worksheet A-8-1

Date/Time Prepared:
11/26/2013 9:54 am

	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	0	0	1.00
2.00	0	0	2.00
3.00	0	0	3.00
4.00	-1,970,440	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	0	0	4.10
4.11	0	0	4.11
4.12	0	0	4.12
4.13	0	0	4.13
4.14	0	0	4.14
4.15	0	0	4.15
4.16	1,497,923	9	4.16
4.17	1,454,107	0	4.17
4.18	0	0	4.18
4.19	219,740	0	4.19
4.20	2,364,544	0	4.20
4.21	28	0	4.21
4.22	-86,084	0	4.22
4.23	-579,591	11	4.23
4.24	-466,356	0	4.24
4.25	-541,441	10	4.25
4.26	0	9	4.26
4.27	0	9	4.27
4.28	0	0	4.28
4.29	0	0	4.29
4.30	0	0	4.30
4.31	0	0	4.31
4.32	0	0	4.32
4.33	0	0	4.33
4.34	0	0	4.34
4.35	0	0	4.35
4.36	0	0	4.36
4.37	0	0	4.37
4.38	0	0	4.38
4.39	0	0	4.39
4.40	0	0	4.40
4.41	0	0	4.41
5.00	1,892,430		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	HEALTH SVCS	6.00
7.00	HEALTH MGMT	7.00
8.00	PROPERTY MGMT	8.00

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

Provider CCN: 150153

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

Worksheet A-8-1

Date/Time Prepared:
11/26/2013 9:54 am

	Related Organization(s) and/or Home Office		
	Type of Business		
6.00	HEALTH MGMT		9.00
9.00			10.00
10.00			100.00

(I) 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: 150153

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

Worksheet A-8-2

Date/Time Prepared:
11/26/2013 9:54 am

	wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	50.00	OPERATING ROOM	873,531	873,531	0	0	0	1.00
2.00	50.00	OPERATING ROOM	6,500	6,500	0	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	91,907	91,907	0	0	0	3.00
4.00	91.00	EMERGENCY	810,389	810,389	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		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			1,782,327	1,782,327	0	0	0	200.00
	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	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	50.00	OPERATING ROOM	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		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
	wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	50.00	OPERATING ROOM	0	0	0	873,531		1.00
2.00	50.00	OPERATING ROOM	0	0	0	6,500		2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	91,907		3.00
4.00	91.00	EMERGENCY	0	0	0	810,389		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		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	1,782,327		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150153

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

Worksheet B
Part I
Date/Time Prepared:
11/26/2013 9:54 am

Cost Center Description	Net Expenses for Cost Allocation (from wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
		1.00	2.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	2,695,743	2,695,743			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	4,725,209		4,725,209		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	10,781,095	9,552	16,744	10,807,391	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	13,814,598	189,884	332,837	1,548,681	15,886,000
7.00 00700	OPERATION OF PLANT	3,933,798	483,003	846,627	191,968	5,455,396
8.00 00800	LAUNDRY & LINEN SERVICE	451,370	5,334	9,349	10,841	476,894
9.00 00900	HOUSEKEEPING	849,000	77,147	135,226	0	1,061,373
10.00 01000	DIETARY	422,591	58,939	103,310	0	584,840
11.00 01100	CAFETERIA	817,412	57,921	101,526	0	976,859
13.00 01300	NURSING ADMINISTRATION	1,189,759	56,878	99,698	370,159	1,716,494
15.00 01500	PHARMACY	1,919,616	61,969	108,623	690,260	2,780,468
16.00 01600	MEDICAL RECORDS & LIBRARY	2,913,932	63,254	110,875	164,253	3,252,314
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	13,629,567	950,901	1,666,779	4,581,980	20,829,227
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	3,275,878	267,370	468,658	1,197,814	5,209,720
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,679,113	53,557	93,876	373,365	2,199,911
59.00 05900	CARDIAC CATHETERIZATION	2,351,759	151,287	265,182	647,384	3,415,612
60.00 06000	LABORATORY	3,018,597	30,985	54,311	0	3,103,893
65.00 06500	RESPIRATORY THERAPY	1,412,351	96,251	168,713	472,556	2,149,871
66.00 06600	PHYSICAL THERAPY	286,346	0	0	98,290	384,636
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	11,074,877	0	0	0	11,074,877
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	14,745,687	0	0	0	14,745,687
73.00 07300	DRUGS CHARGED TO PATIENTS	2,919,852	0	0	0	2,919,852
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	1,348,032	81,511	142,875	459,840	2,032,258
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					0
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	100,256,182	2,695,743	4,725,209	10,807,391	100,256,182
NONREIMBURSABLE COST CENTERS						
193.00 19300	NONPAID WORKERS	0	0	0	0	0
193.01 19301	MARKETING	3,313,744	0	0	0	3,313,744
200.00	Cross Foot Adjustments					0
201.00	Negative Cost Centers		0	0	0	0
202.00	TOTAL (sum lines 118-201)	103,569,926	2,695,743	4,725,209	10,807,391	103,569,926

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150153

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

Worksheet B
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						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500	15,886,000					5.00
7.00	00700	988,370	6,443,766				7.00
8.00	00800	86,400	17,071	580,365			8.00
9.00	00900	192,292	246,915	0	1,500,580		9.00
10.00	01000	105,957	188,639	0	45,806	925,242	10.00
11.00	01100	176,980	185,380	0	45,014	0	11.00
13.00	01300	310,982	182,044	0	44,204	0	13.00
15.00	01500	503,746	198,339	0	48,161	0	15.00
16.00	01600	589,231	202,452	0	49,159	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	3,773,735	3,043,448	362,728	739,012	914,961	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	943,861	855,744	55,804	207,793	0	50.00
54.00	05400	398,564	171,413	39,063	41,623	0	54.00
59.00	05900	618,817	484,208	39,063	117,576	0	59.00
60.00	06000	562,342	99,169	0	24,080	0	60.00
65.00	06500	389,499	308,062	27,903	74,804	397	65.00
66.00	06600	69,686	0	0	0	0	66.00
71.00	07100	2,006,469	0	0	0	0	71.00
72.00	07200	2,671,520	0	0	0	0	72.00
73.00	07300	528,998	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	368,190	260,882	55,804	63,348	9,884	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
118.00		15,285,639	6,443,766	580,365	1,500,580	925,242	118.00
NONREIMBURSABLE COST CENTERS							
193.00	19300	0	0	0	0	0	193.00
193.01	19301	600,361	0	0	0	0	193.01
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		15,886,000	6,443,766	580,365	1,500,580	925,242	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150153

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

Worksheet B
Part I
Date/Time Prepared:
11/26/2013 9:54 am

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
		11.00	13.00	15.00	16.00	24.00	
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	1,384,233					11.00
13.00	01300	43,609	2,297,333				13.00
15.00	01500	0	0	3,530,714			15.00
16.00	01600	34,825	59,676	0	4,187,657		16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	733,708	1,257,306	0	696,355	32,350,480	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	152,664	261,610	0	386,199	8,073,395	50.00
54.00	05400	69,132	118,467	0	336,185	3,374,358	54.00
59.00	05900	117,611	201,541	0	1,228,734	6,223,162	59.00
60.00	06000	0	0	0	257,989	4,047,473	60.00
65.00	06500	74,991	128,506	0	132,143	3,286,176	65.00
66.00	06600	14,339	24,572	0	20,783	514,016	66.00
71.00	07100	0	0	0	273,628	13,354,974	71.00
72.00	07200	0	0	0	461,813	17,879,020	72.00
73.00	07300	76,717	131,464	3,530,714	317,621	7,505,366	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	66,637	114,191	0	76,207	3,047,401	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
118.00		1,384,233	2,297,333	3,530,714	4,187,657	99,655,821	118.00
NONREIMBURSABLE COST CENTERS							
193.00	19300	0	0	0	0	0	193.00
193.01	19301	0	0	0	0	3,914,105	193.01
200.00						0	200.00
201.00		0	0	0	0	0	201.00
202.00		1,384,233	2,297,333	3,530,714	4,187,657	103,569,926	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150153

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

Worksheet B
Part I
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Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		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
13.00	01300	NURSING ADMINISTRATION		13.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	32,350,480
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	8,073,395
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,374,358
59.00	05900	CARDIAC CATHETERIZATION	0	6,223,162
60.00	06000	LABORATORY	0	4,047,473
65.00	06500	RESPIRATORY THERAPY	0	3,286,176
66.00	06600	PHYSICAL THERAPY	0	514,016
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	13,354,974
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	17,879,020
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,505,366
OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	3,047,401
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	
SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	99,655,821
NONREIMBURSABLE COST CENTERS				
193.00	19300	NONPAID WORKERS	0	0
193.01	19301	MARKETING	0	3,914,105
200.00		Cross Foot Adjustments	0	0
201.00		Negative Cost Centers	0	0
202.00		TOTAL (sum lines 118-201)	0	103,569,926

Provider CCN: 150153

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

Worksheet Non-CMS W
 Date/Time Prepared:
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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	S	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	11.00
13.00	NURSING ADMINISTRATION	11	HOURS	13.00
15.00	PHARMACY	15	COSTED REQUIS.	15.00
16.00	MEDICAL RECORDS & LIBRARY	C	GROSS CHARGES	16.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150153

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

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		1.00	2.00			
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	9,552	16,744	26,296	26,296 4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	189,884	332,837	522,721	3,770 5.00
7.00 00700	OPERATION OF PLANT	0	483,003	846,627	1,329,630	467 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	5,334	9,349	14,683	26 8.00
9.00 00900	HOUSEKEEPING	0	77,147	135,226	212,373	0 9.00
10.00 01000	DIETARY	0	58,939	103,310	162,249	0 10.00
11.00 01100	CAFETERIA	0	57,921	101,526	159,447	0 11.00
13.00 01300	NURSING ADMINISTRATION	0	56,878	99,698	156,576	901 13.00
15.00 01500	PHARMACY	0	61,969	108,623	170,592	1,680 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	63,254	110,875	174,129	400 16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	950,901	1,666,779	2,617,680	11,143 30.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	267,370	468,658	736,028	2,916 50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	53,557	93,876	147,433	909 54.00
59.00 05900	CARDIAC CATHETERIZATION	0	151,287	265,182	416,469	1,576 59.00
60.00 06000	LABORATORY	0	30,985	54,311	85,296	0 60.00
65.00 06500	RESPIRATORY THERAPY	0	96,251	168,713	264,964	1,150 65.00
66.00 06600	PHYSICAL THERAPY	0	0	0	0	239 66.00
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	81,511	142,875	224,386	1,119 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	0 92.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	2,695,743	4,725,209	7,420,952	26,296 118.00
NONREIMBURSABLE COST CENTERS						
193.00 19300	NONPAID WORKERS	0	0	0	0	0 193.00
193.01 19301	MARKETING	0	0	0	0	0 193.01
200.00	Cross Foot Adjustments				0	0 200.00
201.00	Negative Cost Centers		0	0	0	0 201.00
202.00	TOTAL (sum lines 118-201)	0	2,695,743	4,725,209	7,420,952	26,296 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150153

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

Worksheet B
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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						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500	526,491					5.00
7.00	00700	32,754	1,362,851				7.00
8.00	00800	2,863	3,611	21,183			8.00
9.00	00900	6,372	52,222	0	270,967		9.00
10.00	01000	3,511	39,897	0	8,271	213,928	10.00
11.00	01100	5,865	39,208	0	8,128	0	11.00
13.00	01300	10,306	38,502	0	7,982	0	13.00
15.00	01500	16,694	41,949	0	8,697	0	15.00
16.00	01600	19,527	42,818	0	8,877	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	125,096	643,686	13,239	133,448	211,551	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	31,279	180,989	2,037	37,522	0	50.00
54.00	05400	13,208	36,254	1,426	7,516	0	54.00
59.00	05900	20,507	102,410	1,426	21,231	0	59.00
60.00	06000	18,636	20,974	0	4,348	0	60.00
65.00	06500	12,908	65,155	1,018	13,508	92	65.00
66.00	06600	2,309	0	0	0	0	66.00
71.00	07100	66,494	0	0	0	0	71.00
72.00	07200	88,533	0	0	0	0	72.00
73.00	07300	17,531	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	12,202	55,176	2,037	11,439	2,285	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
118.00		506,595	1,362,851	21,183	270,967	213,928	118.00
NONREIMBURSABLE COST CENTERS							
193.00	19300	0	0	0	0	0	193.00
193.01	19301	19,896	0	0	0	0	193.01
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		526,491	1,362,851	21,183	270,967	213,928	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150153

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

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
		11.00	13.00	15.00	16.00	24.00	
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	212,648					11.00
13.00	01300	6,699	220,966				13.00
15.00	01500	0	0	239,612			15.00
16.00	01600	5,350	5,740	0	256,841		16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	112,713	120,932	0	42,731	4,032,219	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	23,453	25,163	0	23,699	1,063,086	50.00
54.00	05400	10,620	11,395	0	20,630	249,391	54.00
59.00	05900	18,068	19,385	0	75,269	676,341	59.00
60.00	06000	0	0	0	15,831	145,085	60.00
65.00	06500	11,520	12,360	0	8,109	390,784	65.00
66.00	06600	2,203	2,363	0	1,275	8,389	66.00
71.00	07100	0	0	0	16,791	83,285	71.00
72.00	07200	0	0	0	28,339	116,872	72.00
73.00	07300	11,785	12,645	239,612	19,491	301,064	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	10,237	10,983	0	4,676	334,540	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
118.00		212,648	220,966	239,612	256,841	7,401,056	118.00
NONREIMBURSABLE COST CENTERS							
193.00	19300	0	0	0	0	0	193.00
193.01	19301	0	0	0	0	19,896	193.01
200.00						0	200.00
201.00		0	0	0	0	0	201.00
202.00		212,648	220,966	239,612	256,841	7,420,952	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150153

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

Worksheet B
Part II
Date/Time Prepared:
11/26/2013 9:54 am

Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		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
13.00	01300	NURSING ADMINISTRATION		13.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	4,032,219
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	1,063,086
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	249,391
59.00	05900	CARDIAC CATHETERIZATION	0	676,341
60.00	06000	LABORATORY	0	145,085
65.00	06500	RESPIRATORY THERAPY	0	390,784
66.00	06600	PHYSICAL THERAPY	0	8,389
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	83,285
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	116,872
73.00	07300	DRUGS CHARGED TO PATIENTS	0	301,064
OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	334,540
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	
SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	7,401,056
NONREIMBURSABLE COST CENTERS				
193.00	19300	NONPAID WORKERS	0	0
193.01	19301	MARKETING	0	19,896
200.00		Cross Foot Adjustments	0	0
201.00		Negative Cost Centers	0	0
202.00		TOTAL (sum lines 118-201)	0	7,420,952

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150153

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

Worksheet B-1

Date/Time Prepared:
11/26/2013 9:54 am

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	4.00				
GENERAL SERVICE COST CENTERS							
1.00 00100	CAP REL COSTS-BLDG & FIXT	111,189					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		111,189				2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	394	394	30,806,032			4.00
5.00 00500	ADMINISTRATIVE & GENERAL	7,832	7,832	4,414,448	-15,886,000	87,683,926	5.00
7.00 00700	OPERATION OF PLANT	19,922	19,922	547,196	0	5,455,396	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	220	220	30,903	0	476,894	8.00
9.00 00900	HOUSEKEEPING	3,182	3,182	0	0	1,061,373	9.00
10.00 01000	DIETARY	2,431	2,431	0	0	584,840	10.00
11.00 01100	CAFETERIA	2,389	2,389	0	0	976,859	11.00
13.00 01300	NURSING ADMINISTRATION	2,346	2,346	1,055,122	0	1,716,494	13.00
15.00 01500	PHARMACY	2,556	2,556	1,967,556	0	2,780,468	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	2,609	2,609	468,196	0	3,252,314	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	39,221	39,221	13,060,767	0	20,829,227	30.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	11,028	11,028	3,414,318	0	5,209,720	50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	2,209	2,209	1,064,260	0	2,199,911	54.00
59.00 05900	CARDIAC CATHETERIZATION	6,240	6,240	1,845,339	0	3,415,612	59.00
60.00 06000	LABORATORY	1,278	1,278	0	0	3,103,893	60.00
65.00 06500	RESPIRATORY THERAPY	3,970	3,970	1,347,001	0	2,149,871	65.00
66.00 06600	PHYSICAL THERAPY	0	0	280,171	0	384,636	66.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	11,074,877	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	14,745,687	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	2,919,852	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00 09100	EMERGENCY	3,362	3,362	1,310,755	0	2,032,258	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	111,189	111,189	30,806,032	-15,886,000	84,370,182	118.00
NONREIMBURSABLE COST CENTERS							
193.00 19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01 19301	MARKETING	0	0	0	0	3,313,744	193.01
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per wkst. B, Part I)	2,695,743	4,725,209	10,807,391		15,886,000	202.00
203.00	Unit cost multiplier (wkst. B, Part I)	24.244691	42.497091	0.350821		0.181173	203.00
204.00	Cost to be allocated (per wkst. B, Part II)			26,296		526,491	204.00
205.00	Unit cost multiplier (wkst. B, Part II)			0.000854		0.006004	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150153

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

Worksheet B-1

Date/Time Prepared:
11/26/2013 9:54 am

Cost Center Description		OPERATION OF PLANT (SQURE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS)	
		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	83,041				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	220	597,180			8.00
9.00	00900	HOUSEKEEPING	3,182	0	79,639		9.00
10.00	01000	DIETARY	2,431	0	2,431	58,228	10.00
11.00	01100	CAFETERIA	2,389	0	2,389	0	773,828
13.00	01300	NURSING ADMINISTRATION	2,346	0	2,346	0	24,379
15.00	01500	PHARMACY	2,556	0	2,556	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	2,609	0	2,609	0	19,468
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	39,221	373,237	39,221	57,581	410,165
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	11,028	57,421	11,028	0	85,344
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,209	40,195	2,209	0	38,647
59.00	05900	CARDIAC CATHETERIZATION	6,240	40,195	6,240	0	65,748
60.00	06000	LABORATORY	1,278	0	1,278	0	0
65.00	06500	RESPIRATORY THERAPY	3,970	28,711	3,970	25	41,922
66.00	06600	PHYSICAL THERAPY	0	0	0	0	8,016
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	42,887
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	3,362	57,421	3,362	622	37,252
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	83,041	597,180	79,639	58,228	773,828
NONREIMBURSABLE COST CENTERS							
193.00	19300	NONPAID WORKERS	0	0	0	0	0
193.01	19301	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)	6,443,766	580,365	1,500,580	925,242	1,384,233
203.00		Unit cost multiplier (wkst. B, Part I)	77.597404	0.971843	18.842276	15.889984	1.788812
204.00		Cost to be allocated (per wkst. B, Part II)	1,362,851	21,183	270,967	213,928	212,648
205.00		Unit cost multiplier (wkst. B, Part II)	16.411785	0.035472	3.402441	3.673971	0.274800

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150153

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

Worksheet B-1

Date/Time Prepared:
11/26/2013 9:54 am

Cost Center Description		NURSING ADMINISTRATION (HOURS)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		13.00	15.00	16.00	
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				11.00
13.00	01300	749,449			13.00
15.00	01500	0	1,000		15.00
16.00	01600	19,468	0	434,813,459	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	410,165	0	72,303,487	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	85,344	0	40,099,616	50.00
54.00	05400	38,647	0	34,906,532	54.00
59.00	05900	65,748	0	127,584,380	59.00
60.00	06000	0	0	26,787,307	60.00
65.00	06500	41,922	0	13,720,596	65.00
66.00	06600	8,016	0	2,157,919	66.00
71.00	07100	0	0	28,411,215	71.00
72.00	07200	0	0	47,950,697	72.00
73.00	07300	42,887	1,000	32,979,012	73.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	37,252	0	7,912,698	91.00
92.00	09200				92.00
SPECIAL PURPOSE COST CENTERS					
118.00		749,449	1,000	434,813,459	118.00
NONREIMBURSABLE COST CENTERS					
193.00	19300	0	0	0	193.00
193.01	19301	0	0	0	193.01
200.00					200.00
201.00					201.00
202.00		2,297,333	3,530,714	4,187,657	202.00
203.00		3.065363	3,530.714000	0.009631	203.00
204.00		220,966	239,612	256,841	204.00
205.00		0.294838	239.612000	0.000591	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150153

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

Worksheet C
Part I
Date/Time Prepared:
11/26/2013 9:54 am

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
				Total Costs	RCE	Total Costs		
					Disallowance			
1.00	2.00	3.00	4.00	5.00				
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	32,350,480		32,350,480	0	32,350,480	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	8,073,395		8,073,395	0	8,073,395	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,374,358		3,374,358	0	3,374,358	54.00
59.00	05900	CARDIAC CATHETERIZATION	6,223,162		6,223,162	0	6,223,162	59.00
60.00	06000	LABORATORY	4,047,473		4,047,473	0	4,047,473	60.00
65.00	06500	RESPIRATORY THERAPY	3,286,176	0	3,286,176	0	3,286,176	65.00
66.00	06600	PHYSICAL THERAPY	514,016	0	514,016	0	514,016	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	13,354,974		13,354,974	0	13,354,974	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	17,879,020		17,879,020	0	17,879,020	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,505,366		7,505,366	0	7,505,366	73.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	3,047,401		3,047,401	0	3,047,401	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,421,365		2,421,365	0	2,421,365	92.00
200.00		Subtotal (see instructions)	102,077,186	0	102,077,186	0	102,077,186	200.00
201.00		Less Observation Beds	2,421,365		2,421,365	0	2,421,365	201.00
202.00		Total (see instructions)	99,655,821	0	99,655,821	0	99,655,821	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150153

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

Worksheet C
Part I
Date/Time Prepared:
11/26/2013 9:54 am

		Title XVIII			Hospital	PPS	
Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
				9.00	10.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	69,154,092		69,154,092		30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	33,185,570	6,914,046	40,099,616	0.201333	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	17,570,938	17,335,594	34,906,532	0.096668	54.00
59.00	05900	CARDIAC CATHETERIZATION	81,798,837	45,785,543	127,584,380	0.048777	59.00
60.00	06000	LABORATORY	22,266,786	4,520,521	26,787,307	0.151097	60.00
65.00	06500	RESPIRATORY THERAPY	9,781,384	3,939,212	13,720,596	0.239507	65.00
66.00	06600	PHYSICAL THERAPY	2,073,659	84,260	2,157,919	0.238200	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	24,744,946	3,666,269	28,411,215	0.470060	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	35,536,135	12,414,562	47,950,697	0.372863	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	29,625,151	3,353,861	32,979,012	0.227580	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	2,661,501	5,251,197	7,912,698	0.385128	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	3,149,395	3,149,395	0.768835	92.00
200.00		Subtotal (see instructions)	328,398,999	106,414,460	434,813,459		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	328,398,999	106,414,460	434,813,459		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150153

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

Worksheet C
Part I
Date/Time Prepared:
11/26/2013 9:54 am

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.201333			50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.096668			54.00
59.00	05900 CARDIAC CATHETERIZATION	0.048777			59.00
60.00	06000 LABORATORY	0.151097			60.00
65.00	06500 RESPIRATORY THERAPY	0.239507			65.00
66.00	06600 PHYSICAL THERAPY	0.238200			66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.470060			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.372863			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.227580			73.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY	0.385128			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.768835			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: 150153

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

Worksheet C
Part I
Date/Time Prepared:
11/26/2013 9:54 am

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Title XIX		Hospital		Cost
				Total Costs	RCE Disallowance	Total Costs		
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	32,350,480		32,350,480	0	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	8,073,395		8,073,395	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,374,358		3,374,358	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	6,223,162		6,223,162	0	0	59.00
60.00	06000	LABORATORY	4,047,473		4,047,473	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	3,286,176	0	3,286,176	0	0	65.00
66.00	06600	PHYSICAL THERAPY	514,016	0	514,016	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	13,354,974		13,354,974	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	17,879,020		17,879,020	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,505,366		7,505,366	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	3,047,401		3,047,401	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,421,365		2,421,365	0	0	92.00
200.00		Subtotal (see instructions)	102,077,186	0	102,077,186	0	0	200.00
201.00		Less Observation Beds	2,421,365		2,421,365	0	0	201.00
202.00		Total (see instructions)	99,655,821	0	99,655,821	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150153

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

Worksheet C
Part I
Date/Time Prepared:
11/26/2013 9:54 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	69,154,092		69,154,092		30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	33,185,570	6,914,046	40,099,616	0.201333	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	17,570,938	17,335,594	34,906,532	0.096668	54.00
59.00	05900	CARDIAC CATHETERIZATION	81,798,837	45,785,543	127,584,380	0.048777	59.00
60.00	06000	LABORATORY	22,266,786	4,520,521	26,787,307	0.151097	60.00
65.00	06500	RESPIRATORY THERAPY	9,781,384	3,939,212	13,720,596	0.239507	65.00
66.00	06600	PHYSICAL THERAPY	2,073,659	84,260	2,157,919	0.238200	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	24,744,946	3,666,269	28,411,215	0.470060	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	35,536,135	12,414,562	47,950,697	0.372863	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	29,625,151	3,353,861	32,979,012	0.227580	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	2,661,501	5,251,197	7,912,698	0.385128	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	3,149,395	3,149,395	0.768835	92.00
200.00		Subtotal (see instructions)	328,398,999	106,414,460	434,813,459		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	328,398,999	106,414,460	434,813,459		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150153

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

Worksheet C
Part I
Date/Time Prepared:
11/26/2013 9:54 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
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000			50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000			59.00
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
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: 150153

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

Worksheet C
Part II
Date/Time Prepared:
11/26/2013 9:54 am

Cost Center Description		Title XIX			Hospital		
		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	8,073,395	1,063,086	7,010,309	0	0 50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,374,358	249,391	3,124,967	0	0 54.00
59.00	05900	CARDIAC CATHETERIZATION	6,223,162	676,341	5,546,821	0	0 59.00
60.00	06000	LABORATORY	4,047,473	145,085	3,902,388	0	0 60.00
65.00	06500	RESPIRATORY THERAPY	3,286,176	390,784	2,895,392	0	0 65.00
66.00	06600	PHYSICAL THERAPY	514,016	8,389	505,627	0	0 66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	13,354,974	83,285	13,271,689	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	17,879,020	116,872	17,762,148	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,505,366	301,064	7,204,302	0	0 73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	3,047,401	334,540	2,712,861	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,421,365	301,804	2,119,561	0	0 92.00
200.00		Subtotal (sum of lines 50 thru 199)	69,726,706	3,670,641	66,056,065	0	0 200.00
201.00		Less Observation Beds	2,421,365	301,804	2,119,561	0	0 201.00
202.00		Total (line 200 minus line 201)	67,305,341	3,368,837	63,936,504	0	0 202.00

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

Provider CCN: 150153

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

Worksheet C Part II Date/Time Prepared: 11/26/2013 9:54 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	8,073,395	40,099,616	0.201333		50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	3,374,358	34,906,532	0.096668		54.00
59.00	05900 CARDIAC CATHETERIZATION	6,223,162	127,584,380	0.048777		59.00
60.00	06000 LABORATORY	4,047,473	26,787,307	0.151097		60.00
65.00	06500 RESPIRATORY THERAPY	3,286,176	13,720,596	0.239507		65.00
66.00	06600 PHYSICAL THERAPY	514,016	2,157,919	0.238200		66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	13,354,974	28,411,215	0.470060		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	17,879,020	47,950,697	0.372863		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	7,505,366	32,979,012	0.227580		73.00
OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	3,047,401	7,912,698	0.385128		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2,421,365	3,149,395	0.768835		92.00
200.00	Subtotal (sum of lines 50 thru 199)	69,726,706	365,659,367			200.00
201.00	Less Observation Beds	2,421,365	0			201.00
202.00	Total (line 200 minus line 201)	67,305,341	365,659,367			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 150153

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

Worksheet D
Part I
Date/Time Prepared:
11/26/2013 9:54 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	Per Diem (col. 3 / col. 4)	PPS
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	4,032,219	0	4,032,219	22,686	177.74	30.00
200.00	Total (lines 30-199)	4,032,219		4,032,219	22,686		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	11,871	2,109,952				
200.00	Total (lines 30-199)	11,871	2,109,952				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 150153	Period: From 07/01/2012 To 06/30/2013	Worksheet D Part II Date/Time Prepared: 11/26/2013 9:54 am
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Cost Center Description		Capital Related Cost (from wkst. B, Part II, col. 26)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	1,063,086	40,099,616	0.026511	24,775,880	656,833	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	249,391	34,906,532	0.007145	8,167,741	58,359	54.00
59.00	05900 CARDIAC CATHETERIZATION	676,341	127,584,380	0.005301	36,466,655	193,310	59.00
60.00	06000 LABORATORY	145,085	26,787,307	0.005416	15,153,404	82,071	60.00
65.00	06500 RESPIRATORY THERAPY	390,784	13,720,596	0.028482	5,327,010	151,724	65.00
66.00	06600 PHYSICAL THERAPY	8,389	2,157,919	0.003888	1,343,991	5,225	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	83,285	28,411,215	0.002931	13,347,031	39,120	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	116,872	47,950,697	0.002437	23,088,459	56,267	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	301,064	32,979,012	0.009129	15,844,593	144,645	73.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	334,540	7,912,698	0.042279	1,421,264	60,090	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	301,804	3,149,395	0.095829	0	0	92.00
200.00	Total (lines 50-199)	3,670,641	365,659,367		144,936,028	1,447,644	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150153

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

Worksheet D
Part III
Date/Time Prepared:
11/26/2013 9:54 am

		Title XVIII			Hospital	PPS	
Cost Center Description		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	30.00
200.00		Total (lines 30-199)	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	22,686	0.00	11,871	0	30.00
200.00		Total (lines 30-199)	22,686		11,871	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			30.00
200.00		Total (lines 30-199)	0	0			200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150153

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

Worksheet D
Part IV
Date/Time Prepared:
11/26/2013 9:54 am

Cost Center Description	Title XVIII				Hospital	PPS	Total Cost (sum of col 1 through col. 4)	
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost				
	1.00	2.00	3.00	4.00		5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
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
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: 150153

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

Worksheet D
Part IV
Date/Time Prepared:
11/26/2013 9:54 am

Cost Center Description		Title XVIII			Hospital		PPS	
		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	40,099,616	0.000000	0.000000	24,775,880	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	34,906,532	0.000000	0.000000	8,167,741	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	127,584,380	0.000000	0.000000	36,466,655	59.00
60.00	06000	LABORATORY	0	26,787,307	0.000000	0.000000	15,153,404	60.00
65.00	06500	RESPIRATORY THERAPY	0	13,720,596	0.000000	0.000000	5,327,010	65.00
66.00	06600	PHYSICAL THERAPY	0	2,157,919	0.000000	0.000000	1,343,991	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	28,411,215	0.000000	0.000000	13,347,031	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	47,950,697	0.000000	0.000000	23,088,459	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	32,979,012	0.000000	0.000000	15,844,593	73.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	7,912,698	0.000000	0.000000	1,421,264	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	3,149,395	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	365,659,367			144,936,028	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150153	Period: From 07/01/2012 To 06/30/2013	Worksheet D Part IV Date/Time Prepared: 11/26/2013 9:54 am
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Cost Center Description	Title XVIII			Hospital		PPS
	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
	11.00	12.00	13.00	21.00	22.00	
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	6,411,373	0	0	0 50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	8,654,729	0	0	0 54.00
59.00	05900 CARDIAC CATHETERIZATION	0	18,920,264	0	0	0 59.00
60.00	06000 LABORATORY	0	35,356	0	0	0 60.00
65.00	06500 RESPIRATORY THERAPY	0	92,759	0	0	0 65.00
66.00	06600 PHYSICAL THERAPY	0	27,654	0	0	0 66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,896,125	0	0	0 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	7,613,827	0	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	1,573,802	0	0	0 73.00
OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	0	2,112,042	0	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1,393,561	0	0	0 92.00
200.00	Total (lines 50-199)	0	48,731,492	0	0	0 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150153

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

Worksheet D
Part IV
Date/Time Prepared:
11/26/2013 9:54 am

Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	
		23.00	24.00	
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	59.00
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
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: 150153	Period: From 07/01/2012 To 06/30/2013	Worksheet D Part V Date/Time Prepared: 11/26/2013 9:54 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	0.201333	6,411,373	0	0	1,290,821	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.096668	8,654,729	0	0	836,635	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.048777	18,920,264	0	0	922,874	59.00
60.00	06000	LABORATORY	0.151097	35,356	0	0	5,342	60.00
65.00	06500	RESPIRATORY THERAPY	0.239507	92,759	0	0	22,216	65.00
66.00	06600	PHYSICAL THERAPY	0.238200	27,654	0	0	6,587	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.470060	1,896,125	0	0	891,293	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.372863	7,613,827	0	0	2,838,914	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.227580	1,573,802	0	7,139	358,166	73.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0.385128	2,112,042	0	0	813,407	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.768835	1,393,561	0	0	1,071,418	92.00
200.00		Subtotal (see instructions)		48,731,492	0	7,139	9,057,673	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		48,731,492	0	7,139	9,057,673	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150153	Period: From 07/01/2012 To 06/30/2013	Worksheet D Part V Date/Time Prepared: 11/26/2013 9:54 am
	Title XVIII	Hospital	PPS

Cost Center Description	Costs			
	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
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	59.00
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
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	1,625	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	1,625	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	0	1,625	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 150153

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

Worksheet D
Part I
Date/Time Prepared:
11/26/2013 9:54 am

Cost Center Description		Capital Related Cost (from wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	Cost	
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	4,032,219	0	4,032,219	22,686	177.74	30.00	
200.00	Total (lines 30-199)	4,032,219		4,032,219	22,686		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	491	87,270					30.00
200.00	Total (lines 30-199)	491	87,270					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 150153		Period: From 07/01/2012 To 06/30/2013		Worksheet D Part II Date/Time Prepared: 11/26/2013 9:54 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	1,063,086	40,099,616	0.026511	957,506	25,384	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	249,391	34,906,532	0.007145	484,238	3,460	54.00
59.00	05900	CARDIAC CATHETERIZATION	676,341	127,584,380	0.005301	3,294,563	17,464	59.00
60.00	06000	LABORATORY	145,085	26,787,307	0.005416	559,546	3,031	60.00
65.00	06500	RESPIRATORY THERAPY	390,784	13,720,596	0.028482	279,394	7,958	65.00
66.00	06600	PHYSICAL THERAPY	8,389	2,157,919	0.003888	46,944	183	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	83,285	28,411,215	0.002931	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	116,872	47,950,697	0.002437	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	301,064	32,979,012	0.009129	756,598	6,907	73.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	334,540	7,912,698	0.042279	28,817	1,218	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	3,149,395	0.000000	0	0	92.00
200.00		Total (lines 50-199)	3,368,837	365,659,367		6,407,606	65,605	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS Provider CCN: 150153 Period: From 07/01/2012 To 06/30/2013 Worksheet D Part III Date/Time Prepared: 11/26/2013 9:54 am

Cost Center Description		Title XIX			Hospital	Cost	
Cost Center Description		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	30.00
200.00		Total (lines 30-199)	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	22,686	0.00	491	0	30.00
200.00		Total (lines 30-199)	22,686		491	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			30.00
200.00		Total (lines 30-199)	0	0			200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150153

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

Worksheet D
Part IV
Date/Time Prepared:
11/26/2013 9:54 am

Cost Center Description	Title XIX				Hospital	Total Cost (sum of col 1 through col. 4)	
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Cost		
	1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
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
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: 150153

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

Worksheet D
Part IV
Date/Time Prepared:
11/26/2013 9:54 am

Cost Center Description		Title XIX			Hospital		Cost	
		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	40,099,616	0.000000	0.000000	957,506	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	34,906,532	0.000000	0.000000	484,238	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	127,584,380	0.000000	0.000000	3,294,563	59.00
60.00	06000	LABORATORY	0	26,787,307	0.000000	0.000000	559,546	60.00
65.00	06500	RESPIRATORY THERAPY	0	13,720,596	0.000000	0.000000	279,394	65.00
66.00	06600	PHYSICAL THERAPY	0	2,157,919	0.000000	0.000000	46,944	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	28,411,215	0.000000	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	47,950,697	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	32,979,012	0.000000	0.000000	756,598	73.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	7,912,698	0.000000	0.000000	28,817	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	3,149,395	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	365,659,367			6,407,606	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150153

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

Worksheet D
Part IV
Date/Time Prepared:
11/26/2013 9:54 am

Cost Center Description		Title XIX			Hospital			
		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 Cost		
		11.00	12.00	13.00	21.00	22.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	209,314	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	328,976	0	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,272,378	0	0	0	59.00
60.00	06000	LABORATORY	0	103,513	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	52,340	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,417	0	0	0	66.00
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	102,890	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	94,140	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	2,164,968	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150153

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

Worksheet D
Part IV
Date/Time Prepared:
11/26/2013 9:54 am

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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
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
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: 150153

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

Worksheet D
Part V
Date/Time Prepared:
11/26/2013 9:54 am

		Title XIX		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	0.201333	209,314	0	0	42,142	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.096668	328,976	0	0	31,801	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.048777	1,272,378	0	0	62,063	59.00
60.00	06000	LABORATORY	0.151097	103,513	0	0	15,641	60.00
65.00	06500	RESPIRATORY THERAPY	0.239507	52,340	0	0	12,536	65.00
66.00	06600	PHYSICAL THERAPY	0.238200	1,417	0	0	338	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.470060	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.372863	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.227580	102,890	0	0	23,416	73.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0.385128	94,140	0	0	36,256	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.768835	0	0	0	0	92.00
200.00		Subtotal (see instructions)		2,164,968	0	0	224,193	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		2,164,968	0	0	224,193	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 150153

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

Worksheet D
Part V
Date/Time Prepared:
11/26/2013 9:54 am

		Title XIX		Hospital	Cost
Cost Center Description	Costs				
	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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
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
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		201.00
202.00		Net Charges (line 200 +/- line 201)	0	0	202.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 150153	Period: From 07/01/2012 To 06/30/2013	Worksheet D-1 Date/Time Prepared: 11/26/2013 9:54 am
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Cost Center Description	Title XVIII	Hospital	PPS
			1.00

PART I - ALL PROVIDER COMPONENTS			
INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		22,686 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		22,686 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)		20,988 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0 5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0 7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		11,871 9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0 10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0 14.00
15.00	Total nursery days (title V or XIX only)		0 15.00
16.00	Nursery days (title V or XIX only)		0 16.00
SWING BED ADJUSTMENT			
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00 17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00 18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00 20.00
21.00	Total general inpatient routine service cost (see instructions)		32,350,480 21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0 22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0 23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0 24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0 25.00
26.00	Total swing-bed cost (see instructions)		0 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		32,350,480 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)		32,350,480 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)		1,426.01 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		16,928,165 39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0 40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		16,928,165 41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 150153

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

Worksheet D-1

Date/Time Prepared:
11/26/2013 9:54 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)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					30,478,142	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					47,406,307	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)					2,109,952	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from wkst. D, sum of Parts II and IV)					1,447,644	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					3,557,596	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					43,848,711	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)					1,698	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,426.01	88.00
89.00	observation bed cost (line 87 x line 88) (see instructions)					2,421,365	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 150153

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

Worksheet D-1

Date/Time Prepared:
11/26/2013 9:54 am

Cost Center Description	Title XVIII			Hospital	PPS	
	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	4,032,219	32,350,480	0.124642	2,421,365	301,804	90.00
91.00 Nursing School cost	0	32,350,480	0.000000	2,421,365	0	91.00
92.00 Allied health cost	0	32,350,480	0.000000	2,421,365	0	92.00
93.00 All other Medical Education	0	32,350,480	0.000000	2,421,365	0	93.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 150153

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

Worksheet D-1

Date/Time Prepared:
11/26/2013 9:54 am

Title XIX		Hospital	Cost
Cost Center Description			1.00
PART I - ALL PROVIDER COMPONENTS			
INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	22,686	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	22,686	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)	20,988	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	491	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
SWING BED ADJUSTMENT			
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	32,350,480	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	32,350,480	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)	32,350,480	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)	1,426.01	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	700,171	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)	700,171	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 150153

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

Worksheet D-1

Date/Time Prepared:
11/26/2013 9:54 am

		Title XIX		Hospital	Cost		
Cost Center Description	Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)		
	Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)				
	1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)					42.00	
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT					43.00	
44.00	CORONARY CARE UNIT					44.00	
45.00	BURN INTENSIVE CARE UNIT					45.00	
46.00	SURGICAL INTENSIVE CARE UNIT					46.00	
47.00	OTHER SPECIAL CARE (SPECIFY)					47.00	
	Cost Center Description						
					1.00		
48.00	Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					746,217	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,446,388	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)					1,698	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,426.01	88.00
89.00	observation bed cost (line 87 x line 88) (see instructions)					2,421,365	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 150153

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

Worksheet D-1

Date/Time Prepared:
11/26/2013 9:54 am

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 150153	Period: From 07/01/2012 To 06/30/2013	Worksheet D-3 Date/Time Prepared: 11/26/2013 9:54 am
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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		35,659,826		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.201333	24,775,880	4,988,202	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.096668	8,167,741	789,559	54.00
59.00	05900 CARDIAC CATHETERIZATION	0.048777	36,466,655	1,778,734	59.00
60.00	06000 LABORATORY	0.151097	15,153,404	2,289,634	60.00
65.00	06500 RESPIRATORY THERAPY	0.239507	5,327,010	1,275,856	65.00
66.00	06600 PHYSICAL THERAPY	0.238200	1,343,991	320,139	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.470060	13,347,031	6,273,905	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.372863	23,088,459	8,608,832	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.227580	15,844,593	3,605,912	73.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY	0.385128	1,421,264	547,369	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.768835	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		144,936,028	30,478,142	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)		144,936,028		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 150153

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

Worksheet D-3

Date/Time Prepared:
11/26/2013 9:54 am

Cost Center Description		Title XIX	Hospital	Cost	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		1,653,292	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.201333	957,506	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.096668	484,238	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.048777	3,294,563	59.00
60.00	06000	LABORATORY	0.151097	559,546	60.00
65.00	06500	RESPIRATORY THERAPY	0.239507	279,394	65.00
66.00	06600	PHYSICAL THERAPY	0.238200	46,944	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.470060	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.372863	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.227580	756,598	73.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.385128	28,817	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.768835	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		6,407,606	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)		6,407,606	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 150153

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

Worksheet E
Part A
Date/Time Prepared:
11/26/2013 9:54 am

		Title XVIII	Hospital	PPS
		0	before 1/1	on/after 1/1
			1.00	1.01
PART A - INPATIENT HOSPITAL SERVICES UNDER PPS				
1.00	DRG Amounts Other than Outlier Payments		34,872,569	1.00
2.00	Outlier payments for discharges. (see instructions)		1,484,848	2.00
2.01	Outlier reconciliation amount		0	2.01
3.00	Managed Care Simulated Payments		0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		102.35	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 Federal Register, page 50069, August 1, 2002.		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
Indirect Medical Education Adjustment for the Add-on for section 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C) .		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment. (see instructions)		0.000000	27.00
28.00	IME Adjustment (see instructions)		0	28.00
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		0.00	30.00
31.00	Percentage of Medicaid patient days (see instructions)		3.65	31.00
32.00	Sum of lines 30 and 31		3.65	32.00
33.00	Allowable disproportionate share percentage (see instructions)		0.00	33.00
34.00	Disproportionate share adjustment (see instructions)		0	34.00
Additional payment for high percentage of ESRD beneficiary discharges				
40.00	Total Medicare discharges on worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0	40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0	0 41.00

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CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 150153

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

Worksheet E
Part A
Date/Time Prepared:
11/26/2013 9:54 am

		Title XVIII	Hospital	PPS	
			before 1/1	on/after 1/1	
		0	1.00	1.01	
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGS 652, 682, 683, 684 an 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41)		0		46.00
47.00	Subtotal (see instructions)		36,357,417		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)		0		48.00
49.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)		36,357,417		49.00
50.00	Payment for inpatient program capital (from worksheet L, Parts I, II, as applicable)		2,979,470		50.00
51.00	Exception payment for inpatient program capital (worksheet L, Part III, see instructions)		0		51.00
52.00	Direct graduate medical education payment (from worksheet E-4, line 49 see instructions).		0		52.00
53.00	Nursing and Allied Health Managed Care payment		0		53.00
54.00	Special add-on payments for new technologies		0		54.00
55.00	Net organ acquisition cost (worksheet D-4 Part III, col. 1, line 69)		0		55.00
56.00	Cost of teaching physicians (worksheet D-5, Part II, col. 3, line 20)		0		56.00
57.00	Routine service other pass through costs (from wkst D, Part III, column 9, lines 30-35).		0		57.00
58.00	Ancillary service other pass through costs worksheet D, Part IV, col. 11 line 200)		0		58.00
59.00	Total (sum of amounts on lines 49 through 58)		39,336,887		59.00
60.00	Primary payer payments		45,573		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		39,291,314		61.00
62.00	Deductibles billed to program beneficiaries		2,436,620		62.00
63.00	Coinsurance billed to program beneficiaries		6,668		63.00
64.00	Allowable bad debts (see instructions)		57,301		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		40,111		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		57,301		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		36,888,137		67.00
68.00	Credits received from manufacturers for replaced devices applicable to MS-DRG (see instructions)		0		68.00
69.00	Outlier payments reconciliation (Sum of lines 93, 95 and 96).(For SCH see instructions)		0		69.00
70.00			0		70.00
70.91	OTHER ADJUSTMENTS		23,097		70.91
70.92			0		70.92
70.93	HVBP incentive payment (see instructions)		92,782		70.93
70.94	Hospital readmissions reduction adjustment (see instructions)		-2,647		70.94
70.95	Recovery of Accelerated Depreciation		0		70.95
70.96	Low Volume Payment-1 (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0		70.96
70.97	Low Volume Payment-2 (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0		70.97
70.98	Low Volume Payment-3		0		70.98
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		37,001,369		71.00
71.01	Sequestration adjustment (see instructions)		185,007		71.01
72.00	Interim payments		36,834,092		72.00
73.00	Tentative settlement (for contractor use only)		0		73.00
74.00	Balance due provider (Program) line 71 minus lines 71.01, 72 and 73		-17,730		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		0		75.00
TO BE COMPLETED BY CONTRACTOR					
90.00	Operating outlier amount from Worksheet E, Part A line 2 (see instructions)		0		90.00
91.00	Capital outlier from worksheet L, Part I, line 2		0		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0		92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0		93.00

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CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 150153

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

Worksheet E
Part A
Date/Time Prepared:
11/26/2013 9:54 am

		Title XVIII	Hospital		PPS
			before 1/1	on/after 1/1	
		0	1.00	1.01	
94.00	The rate used to calculate the Time Value of Money		0.00		94.00
95.00	Time Value of Money for operating expenses(see instructions)		0		95.00
96.00	Time Value of Money for capital related expenses (see instructions)		0		96.00

CALCULATION OF DSH PAYMENT PERCENTAGE

Provider CCN: 150153

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

Worksheet DSH
Date/Time Prepared:
11/26/2013 9:54 am

		Title XVIII			Hospital		PPS
		Original .mcrcx Values	Adjusted .mcrcx Values	HFS Look Up	Override Value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
CALCULATION OF THE DSH PAYMENT PERCENTAGE							
1.00	Percentage of SSI patient days to Medicare Part A days (Previous from E, Part A, line 30 - Revised from CMS)	0.00	0.00	0.00	0.00	0.00	1.00
2.00	Percentage of Medicaid patient days to total days (From line 27)	3.65	0.00			3.65	2.00
3.00	Sum of lines 1 and 2, if less than 15% DSH Payment Percentage = 0	3.65	0.00			3.65	3.00
4.00	Provider Type * (Urban, rural, SCH, RRC, pickle - If pickle worksheet NA)	Urban				Urban	4.00
5.00	Bed days available divided by number of days in the cost reporting period (Worksheet E, Part A, Line 4)	102.35	0.00			102.35	5.00
6.00	Disproportionate Share Payment Percentage (transfer to worksheet E, Part A, line 33)	0.00	0.00			0.00	6.00
7.00	Qualify for Operating DSH Eligibility (DPP 15% or more)?	No				No	7.00
8.00	S-2, Line 22	No				No	8.00
9.00	Qualify for Capital DSH Eligibility (Urban with 100 or more beds)?	Yes				No	9.00
10.00	S-2, Line 45	Yes				Yes	10.00
11.00	Is the provider reimbursed under the fully prospective method? (Worksheet L, Part I, line 1 greater than -0-)	Yes				Yes	11.00
12.00	Percentage of SSI patient days to Medicare Part A days (Previous from L, Part I, line 7 - Revised from CMS)	1.80	0.00	0.00	0.00	0.00	12.00
13.00	Is this an IRF provider or a provider with an IRF excluded unit (Worksheet S-2, line 75, column 1 = "Y")	No				No	13.00
14.00	Medicare SSI ratio (Previous from E-3, Part III, line 2 - Revised from CMS)	0.00	0.00	0.00	0.00	0.00	14.00
CALCULATION OF THE PERCENTAGE OF MEDICAID DAYS TO TOTAL DAYS							
15.00	In-State Medicaid paid days (Worksheet S-2, line 24, column 1)	491	0			491	15.00
16.00	In-State Medicaid eligible unpaid paid days (Worksheet S-2, line 24, column 2)	0	0			0	16.00
17.00	Out-of-State Medicaid paid days (Worksheet S-2, line 24, column 3)	0	0			0	17.00
18.00	Out-of-State Medicaid eligible unpaid days (Worksheet S-2, line 24, column 4)	0	0			0	18.00
18.01	N/A	0	0			0	18.01
19.00	Medicaid HMO days (Worksheet S-2, line 24, column 5)	276	0			276	19.00
20.00	Other Medicaid days (Worksheet S-2, line 24, column 6)	0	0			0	20.00
21.00	Total Medicaid patient days for the DSH calculation (sum of lines 15-20)	767	0			767	21.00
22.00	Total patient days (Worksheet S-3, Part I, Column 8, Line 14)	20,988	0			20,988	22.00
23.00	Plus total labor room days (Worksheet S-3, Part I, Column 8, Line 32)	0	0			0	23.00
24.00	Plus total employee discount days (Worksheet S-3, Part I, Column 8, Line 30)	0	0			0	24.00
25.00	Less total Swing-bed SNF and NF patient days (Worksheet S-3, Part I, Column 8, Lines 5 and 6)	0	0			0	25.00
26.00	Total Medicaid patient days for the DSH calculation (sum of lines 22-24, less line 25)	20,988	0			20,988	26.00
27.00	Percentage of Medicaid patient days to total days (Line 21 divided by line 26)	3.65	0.00			3.65	27.00

CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 150153	Period: From 07/01/2012 To 06/30/2013	Worksheet DSH Date/Time Prepared: 11/26/2013 9:54 am
		Title XVIII	Hospital	PPS

		Original .mcrx Values		Adjusted .mcax Values		Revised	
		Condition	Percentage	Condition	Percentage	Condition	
		1.00	2.00	3.00	4.00	5.00	
CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE							
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	False	0.00		0.00	False	28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	True	9.88		0.00	True	29.00
30.00	Line 28 or 29 as applicable		9.88		0.00		30.00
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.		0.00		0.00		31.00
		Original .mcrx Values	Adjusted .mcax Values	HFS Look Up	Override Value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
DETERMINATION OF PROVIDER TYPE							
32.00	Does the hospital qualify under the Pickle ammendment? (Worksheet S-2, Part I, Line 22, column 2 = "Y")	False				False	32.00
33.00	Is This a Rural Referral Center? (Worksheet S-2, Part I, line 116, column 1 = "Y")	False				False	33.00
34.00	Is this a Medicare Dependant Hospital? (Worksheet S-2, Part I, Line 37 greater than -0-)	False				False	34.00
35.00	Is this a Sole Cummunity hospital? (Worksheet S-2, Part I, Line 35 greater than -0-)	False				False	35.00
36.00	Is this an Urban or Rural hospital? (Worksheet S-2, Part I, Line 26, Column 1, Urban=1, Rural=2)	Urban				Urban	36.00

CALCULATION OF DSH PAYMENT PERCENTAGE

Provider CCN: 150153

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

Worksheet DSH

Date/Time Prepared:
11/26/2013 9:54 am

		Title XVIII		Hospital		PPS	
		Revised Percentage					
		6.00					
CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE							
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	0.00				28.00	
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	9.88				29.00	
30.00	Line 28 or 29 as applicable	9.88				30.00	
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.	0.00				31.00	

Provider CCN: 150153

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

Worksheet E
 Part A Exhibit 4
 Date/Time Prepared:
 11/26/2013 9:54 am

		Title XVIII		Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period on/After 10/01	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00	34,872,569	0	0	34,872,569	1.00
2.00	Outlier payments for discharges (see instructions)	2.00	1,484,848	0	0	1,484,848	2.00
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
Indirect Medical Education Adjustment							
5.00	Amount from worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000	5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	Amount from worksheet E Part A, line 27 (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000	7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0000	0.0000	0.0000	0.0000	10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	0	0	0	0	11.00
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	36,357,417	0	0	36,357,417	13.00
14.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)	49.00	36,357,417	0	0	36,357,417	15.00
16.00	Payment for inpatient program capital (from worksheet L, Parts I, as applicable)	50.00	2,979,470	0	0	2,979,470	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			0	0	39,336,887	19.00
		W/S L, line	(Amounts from L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	2,778,877	0	0	2,778,877	20.00
21.00	Capital DRG outlier payments	2.00	169,747	0	0	169,747	21.00
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000	22.00
23.00	Indirect medical education adjustment (line 20 times line 22)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0111	0.0111	0.0111	0.0111	24.00
25.00	Disproportionate share adjustment (line 20 times line 24)	11.00	30,846	0	0	30,846	25.00
26.00	Total prospective capital payments (sum of lines 20-21, 23 and 25)	12.00	2,979,470	0	0	2,979,470	26.00
		W/S E, Part A line	(Amounts to E, Part A)				
		0	1.00	2.00	3.00	4.00	
27.00	Low volume adjustment factor				0.000000	0.000000	27.00
28.00	Low volume adjustment (transfer amount to W/S E Part A line)	70.96			0		28.00
29.00	Low volume adjustment (transfer amount to W/S E Part A line)	70.97				0	29.00
100.00	Transfer low volume adjustments to W/S E Part A.		Y				100.00

		Title XVIII		Hospital	PPS
		Total (Col 2 through 4)			
		5.00			
1.00	DRG amounts other than outlier payments	34,872,569			1.00
2.00	Outlier payments for discharges (see instructions)	1,484,848			2.00
3.00	Operating outlier reconciliation	0			3.00
4.00	Managed care simulated payments	0			4.00
Indirect Medical Education Adjustment					
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)				5.00
6.00	IME payment adjustment (see instructions)	0			6.00
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA					
7.00	Amount from Worksheet E Part A, line 27 (see instructions)				7.00
8.00	IME adjustment (see instructions)	0			8.00
9.00	Total IME payment (sum of lines 6 and 8)	0			9.00
Disproportionate Share Adjustment					
10.00	Allowable disproportionate share percentage (see instructions)				10.00
11.00	Disproportionate share adjustment (see instructions)	0			11.00
Additional payment for high percentage of ESRD beneficiary discharges					
12.00	Total ESRD additional payment (see instructions)	0			12.00
13.00	Subtotal (see instructions)	36,357,417			13.00
14.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0			14.00
15.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)	36,357,417			15.00
16.00	Payment for inpatient program capital (from Worksheet L, Parts I, as applicable)	2,979,470			16.00
17.00	Special add-on payments for new technologies	0			17.00
18.00	Capital outlier reconciliation adjustment amount (see instructions)	0			18.00
19.00	SUBTOTAL	39,336,887			19.00
		5.00			
20.00	Capital DRG other than outlier	2,778,877			20.00
21.00	Capital DRG outlier payments	169,747			21.00
22.00	Indirect medical education percentage (see instructions)				22.00
23.00	Indirect medical education adjustment (line 20 times line 22)	0			23.00
24.00	Allowable disproportionate share percentage (see instructions)				24.00
25.00	Disproportionate share adjustment (line 20 times line 24)	30,846			25.00
26.00	Total prospective capital payments (sum of lines 20-21, 23 and 25)	2,979,470			26.00
		5.00			
27.00	Low volume adjustment factor				27.00
28.00	Low volume adjustment (transfer amount to W/S E Part A line)	0			28.00
29.00	Low volume adjustment (transfer amount to W/S E Part A line)	0			29.00
100.00	Transfer low volume adjustments to W/S E Part A.				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150153	Period: From 07/01/2012 To 06/30/2013	Worksheet E Part B Date/Time Prepared: 11/26/2013 9:54 am
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		1,625	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		9,057,673	2.00
3.00	PPS payments		10,289,061	3.00
4.00	Outlier payment (see instructions)		230,213	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)		1,625	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		7,139	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)		7,139	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		7,139	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		5,514	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)		1,625	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)		10,519,274	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		1,753,150	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)		8,767,749	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)		8,767,749	30.00
31.00	Primary payer payments		6	31.00
32.00	Subtotal (line 30 minus line 31)		8,767,743	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)		174,596	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		122,217	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		174,596	36.00
37.00	Subtotal (see instructions)		8,889,960	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)		8,889,960	40.00
40.01	Sequestration adjustment (see instructions)		44,450	40.01
41.00	Interim payments		8,794,670	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		50,840	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: 150153

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

Worksheet E-1
Part I
Date/Time Prepared:
11/26/2013 9:54 am

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		36,834,092		8,794,670	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to wkst. E or wkst. E-3, line and column as appropriate)		36,834,092		8,794,670	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		167,277		95,290	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		37,001,369		8,889,960	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 150153

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

Worksheet E-3
Part VII
Date/Time Prepared:
11/26/2013 9:54 am

		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			1,446,388			1.00
2.00	Medical and other services				0		2.00
3.00	Organ acquisition (certified transplant centers only)			0			3.00
4.00	Subtotal (sum of lines 1, 2 and 3)			1,446,388		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)			1,446,388		0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES							
Reasonable Charges							
8.00	Routine service charges			1,750,210			8.00
9.00	Ancillary service charges			6,407,606	2,164,968		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)			8,157,816	2,164,968		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)			8,157,816	2,164,968		16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)			6,711,428	2,164,968		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)			1,446,388		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			24.00
25.00	Capital exception payments (see instructions)			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)			1,446,388		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)			1,446,388		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			35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)			1,446,388		0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0		0	37.00
38.00	Subtotal (line 36 ± line 37)			1,446,388		0	38.00
39.00	Direct graduate medical education payments (from wkst. E-4)			0			39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)			1,446,388		0	40.00
41.00	Interim payments			1,446,388		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: 150153

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

Worksheet G

Date/Time Prepared:
11/26/2013 9:54 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	14,981,761	0	0	0	1.00
2.00 Temporary investments	24,238,205	0	0	0	2.00
3.00 Notes receivable	0	0	0	0	3.00
4.00 Accounts receivable	37,539,412	0	0	0	4.00
5.00 Other receivable	1,558,431	0	0	0	5.00
6.00 Allowances for uncollectible notes and accounts receivable	-21,972,920	0	0	0	6.00
7.00 Inventory	1,538,042	0	0	0	7.00
8.00 Prepaid expenses	523,852	0	0	0	8.00
9.00 Other current assets	0	0	0	0	9.00
10.00 Due from other funds	-15,994	15,994	0	0	10.00
11.00 Total current assets (sum of lines 1-10)	58,390,789	15,994	0	0	11.00
FIXED ASSETS					
12.00 Land	0	0	0	0	12.00
13.00 Land improvements	0	0	0	0	13.00
14.00 Accumulated depreciation	0	0	0	0	14.00
15.00 Buildings	42,301,141	0	0	0	15.00
16.00 Accumulated depreciation	-25,184,618	0	0	0	16.00
17.00 Leasehold improvements	0	0	0	0	17.00
18.00 Accumulated depreciation	0	0	0	0	18.00
19.00 Fixed equipment	6,258,340	0	0	0	19.00
20.00 Accumulated depreciation	-6,185,101	0	0	0	20.00
21.00 Automobiles and trucks	0	0	0	0	21.00
22.00 Accumulated depreciation	0	0	0	0	22.00
23.00 Major movable equipment	17,248,137	0	0	0	23.00
24.00 Accumulated depreciation	-11,692,308	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)	22,745,591	0	0	0	30.00
OTHER ASSETS					
31.00 Investments	0	0	0	0	31.00
32.00 Deposits on leases	0	0	0	0	32.00
33.00 Due from owners/officers	0	0	0	0	33.00
34.00 Other assets	274,760	0	0	0	34.00
35.00 Total other assets (sum of lines 31-34)	274,760	0	0	0	35.00
36.00 Total assets (sum of lines 11, 30, and 35)	81,411,140	15,994	0	0	36.00
CURRENT LIABILITIES					
37.00 Accounts payable	7,190,475	0	0	0	37.00
38.00 Salaries, wages, and fees payable	2,754,324	0	0	0	38.00
39.00 Payroll taxes payable	457,024	0	0	0	39.00
40.00 Notes and loans payable (short term)	3,561,153	0	0	0	40.00
41.00 Deferred income	0	0	0	0	41.00
42.00 Accelerated payments	0	0	0	0	42.00
43.00 Due to other funds	0	0	0	0	43.00
44.00 Other current liabilities	1,824,469	0	0	0	44.00
45.00 Total current liabilities (sum of lines 37 thru 44)	15,787,445	0	0	0	45.00
LONG TERM LIABILITIES					
46.00 Mortgage payable	0	0	0	0	46.00
47.00 Notes payable	32,050,384	0	0	0	47.00
48.00 Unsecured loans	0	0	0	0	48.00
49.00 Other long term liabilities	0	0	0	0	49.00
50.00 Total long term liabilities (sum of lines 46 thru 49)	32,050,384	0	0	0	50.00
51.00 Total liabilities (sum of lines 45 and 50)	47,837,829	0	0	0	51.00
CAPITAL ACCOUNTS					
52.00 General fund balance	33,573,311	0	0	0	52.00
53.00 Specific purpose fund	0	15,994	0	0	53.00
54.00 Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00 Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00 Governing body created - endowment fund balance	0	0	0	0	56.00
57.00 Plant fund balance - invested in plant	0	0	0	0	57.00
58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00 Total fund balances (sum of lines 52 thru 58)	33,573,311	15,994	0	0	59.00
60.00 Total liabilities and fund balances (sum of lines 51 and 59)	81,411,140	15,994	0	0	60.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 150153

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
11/26/2013 9:54 am

Cost Center Description	Inpatient	Outpatient	Total	
	1.00	2.00	3.00	
PART I - PATIENT REVENUES				
General Inpatient Routine Services				
1.00 Hospital	72,601,531		72,601,531	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)	72,601,531		72,601,531	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)	72,601,531		72,601,531	17.00
18.00 Ancillary services	259,383,599	94,857,322	354,240,921	18.00
19.00 Outpatient services	2,695,610	5,275,396	7,971,006	19.00
20.00 RURAL HEALTH CLINIC	0	0	0	20.00
21.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00 HOME HEALTH AGENCY				22.00
23.00 AMBULANCE SERVICES				23.00
24.00 CMHC				24.00
25.00 AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00 HOSPICE				26.00
27.00 OTHER (SPECIFY)	0	0	0	27.00
28.00 Total patient revenues (sum of lines 17-27)(transfer column 3 to wkst. G-3, line 1)	334,680,740	100,132,718	434,813,458	28.00
PART II - OPERATING EXPENSES				
29.00 Operating expenses (per wkst. A, column 3, line 200)		108,856,467		29.00
30.00 BAD DEBT EXPENSE	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)		108,856,467		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 150153

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

Worksheet G-3

Date/Time Prepared:
11/26/2013 9:54 am

		1.00	
1.00	Total patient revenues (from wkst. G-2, Part I, column 3, line 28)	434,813,458	1.00
2.00	Less contractual allowances and discounts on patients' accounts	296,699,780	2.00
3.00	Net patient revenues (line 1 minus line 2)	138,113,678	3.00
4.00	Less total operating expenses (from wkst. G-2, Part II, line 43)	108,856,467	4.00
5.00	Net income from service to patients (line 3 minus line 4)	29,257,211	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	480,133	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	508,822	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	12,939	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS REVENUE	40,229	24.00
24.01	OTHER OPERATING REVENUE	67,078	24.01
24.02	ROUNDING	1	24.02
24.03		0	24.03
24.04		0	24.04
25.00	Total other income (sum of lines 6-24)	1,109,202	25.00
26.00	Total (line 5 plus line 25)	30,366,413	26.00
27.00	LOSS ON FIXED ASSETS	47,574	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	47,574	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	30,318,839	29.00

Provider CCN: 150153

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

Worksheet L
 Parts I-III
 Date/Time Prepared:
 11/26/2013 9:54 am

		Title XVIII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		2,778,877	1.00
2.00	Capital DRG outlier payments		169,747	2.00
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		57.50	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (line 1 times line 5)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		1.80	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		3.65	8.00
9.00	Sum of lines 7 and 8		5.45	9.00
10.00	Allowable disproportionate share percentage (see instructions)		1.11	10.00
11.00	Disproportionate share adjustment (line 1 times line 10)		30,846	11.00
12.00	Total prospective capital payments (sum of lines 1-2, 6, and 11)		2,979,470	12.00
				1.00
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
				1.00
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00