

**ST. VINCENT RANDOLPH HOSPITAL
WINCHESTER, INDIANA**

**PROVIDER NOS. 15-1301, 15-Z301
AND AIM NO. 100270270A**

**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: 151301	Period: From 07/01/2012 To 06/30/2013	Worksheet 5 Parts I-III Date/Time Prepared: 11/25/2013 4:00 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: 11/25/2013 Time: 4:00 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 RANDOLPH HOSPITAL (151301) 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: 11/25/2013 Time: 4:00 pm
usyXWAIrn8LGQC2sav01vmfMS04NEO
n4L000AMH6J8AnYkwpVmqiFLidHYPr
jkuh0AKHxt009PTJ
PI: Date: 11/25/2013 Time: 4:00 pm
j9gj0soJBSmwd3u8X7pknob14W6hk0
KMRb30VULDD6x93TONSf8QDwtbu77Q
k55R0umlZq0Dzqzo

(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	296,129	405,047	0	0 1.00
2.00	Subprovider - IPF	0	0	0	0	0 2.00
3.00	Subprovider - IRF	0	0	0	0	0 3.00
4.00	SUBPROVIDER I	0	0	0	0	0 4.00
5.00	Swing bed - SNF	0	74,593	0	0	0 5.00
6.00	Swing bed - NF	0	0	0	0	0 6.00
9.00	HOME HEALTH AGENCY I	0	0	0	0	0 9.00
200.00	Total	0	370,722	405,047	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: 151301	Period: From 07/01/2012 To 06/30/2013	Worksheet S-2 Part I Date/Time Prepared: 11/25/2013 3:32 pm
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	1.00	2.00	3.00	4.00	
Hospital and Hospital Health Care Complex Address:					
1.00	Street: 473 GREENVILLE AVE.		PO Box:		1.00
2.00	City: WINCHESTER		State: IN	Zip Code: 47934	County: RANDOLPH

	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 RANDOLPH HOSPITAL	151301	34620	1	01/01/2000	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	ST. VINCENT RANDOLPH SWING BEDS	152301	34620		09/01/1999	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2012	06/30/2013	20.00
21.00	Type of Control (see instructions)	1		21.00

Inpatient PPS Information				
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	N	23.00

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
	1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	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	25.00

	Urban/Rural S	Date of Geogr	
	1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2	26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2	27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0	35.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151301	Period: From 07/01/2012 To 06/30/2013	Worksheet S-2 Part I Date/Time Prepared: 11/25/2013 3:32 pm			
		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	N	N		45.00	
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete worksheet L, Part III and L-1, Parts I through III.	N	N	N		46.00	
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N		47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00	
Teaching Hospitals							
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N				56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete worksheet E-4. If column 2 is "N", complete worksheet D, Part III & IV and D-2, Part II, if applicable.	N				57.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete worksheet D-5.	N				58.00	
59.00	Are costs claimed on line 100 of worksheet A? If yes, complete worksheet D-2, Part I.	N				59.00	
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N				60.00	
		Y/N 1.00	IME 2.00	Direct GME 3.00	IME 4.00	Direct GME 5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
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	

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		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: 151301		Period: From 07/01/2012 To 06/30/2013		Worksheet S-2 Part I Date/Time Prepared: 11/25/2013 3:32 pm	
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
67.00	Enter in column 1 the program name associated with each of your primary care programs in which you trained residents. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00	
						1.00	2.00 3.00
Inpatient Psychiatric Facility PPS							
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				N		70.00
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)				N	N 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)				N	N 0	76.00
						1.00	
Long Term Care Hospital PPS							
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.					N	80.00
TEFRA Providers							
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.					N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.						86.00
						V	XIX
						1.00	2.00
Title V and XIX Services							
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.				N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.				N	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.					N	92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.				N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.				N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.					0.00	0.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.				N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.					0.00	0.00
Rural Providers							
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?				Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)				N		106.00

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			V 1.00	XIX 2.00		
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&RS in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)		N	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		N			108.00
		Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00
				1.00	2.00	3.00
Miscellaneous Cost Reporting Information						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.			N		0
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 1.00	Losses 2.00	Insurance 3.00	
118.01	List amounts of malpractice premiums and paid losses:	1	0	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		140.00

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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. SUITE 420	PO Box:				142.00		
143.00	City: INDIANAPOLIS	State: IN		Zip Code: 46290		143.00		
1.00								
144.00	Are provider based physicians' costs included in worksheet A?						Y 144.00	
145.00	If costs for renal services are claimed on worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.						N 145.00	
1.00								
2.00								
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.						N 146.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.						N 147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.						N 148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.						N 149.00	
		Part A	Part B	Title V	Title XIX			
		1.00	2.00	3.00	4.00			
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)								
155.00	Hospital	N	N	N	N	155.00		
156.00	Subprovider - IPF	N	N	N	N	156.00		
157.00	Subprovider - IRF	N	N	N	N	157.00		
158.00	SUBPROVIDER					158.00		
159.00	SNF	N	N	N	N	159.00		
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00		
161.00	CMHC		N	N	N	161.00		
1.00								
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	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 151301	Period: From 07/01/2012 To 06/30/2013	Worksheet S-2 Part II Date/Time Prepared: 11/25/2013 3:32 pm		
	Description	Part A		Part B		
		Y/N	Date	Y/N		
21.00	was the cost report prepared only using the provider's records? If yes, see instructions.	0	1.00	2.00	3.00	21.00
			N		N	
					1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)						
Capital Related Cost						
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
Interest Expense						
28.00	were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
Purchased Services						
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
Provider-Based Physicians						
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00
			Y/N	Date		
			1.00	2.00		
Home Office Costs						
36.00	Were home office costs claimed on the cost report?				Y	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				Y	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				N	40.00
			1.00	2.00		
Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	JILL		HILL		41.00
42.00	Enter the employer/company name of the cost report preparer.	ST VINCENT HEALTH				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-583-3232		JILL.HILL@STVINCENT.ORG		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 151301	Period: From 07/01/2012 To 06/30/2013	Worksheet S-2 Part II Date/Time Prepared: 11/25/2013 3:32 pm
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		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.		REIMBURSEMENT 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: 151301

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

Worksheet S-2
Part IX
Date/Time Prepared:
11/25/2013 3:32 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151301

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

Worksheet S-3
Part I
Date/Time Prepared:
11/25/2013 3:32 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	Title V
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	55,872.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	55,872.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		25	9,125	55,872.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF					0	16.00
17.00 SUBPROVIDER - IRF					0	17.00
18.00 SUBPROVIDER	42.00	0	0		0	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	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	116.00	0	0			24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		25				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,186	88	2,328			1.00
2.00 HMO and other (see instructions)	160	379				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	152	0	152			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	83			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	1,338	88	2,563			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		270	427			13.00
14.00 Total (see instructions)	1,338	358	2,990	0.00	158.43	14.00
15.00 CAH visits	13,678	2,442	43,514			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER	0	0	0	0.00	0.00	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	0	0	0	0.00	0.00	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	0	0	0	0.00	0.00	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	158.43	27.00
28.00 Observation Bed Days		0	577			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			30			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)		37	80			32.00
33.00 LTCH non-covered days	0					33.00

Component	Full Time Equivalents	Discharges				Total All Patients	
		Nonpaid workers	Title V	Title XVIII	Title XIX		
		11.00	12.00	13.00	14.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)			0	378	54	929	1.00
2.00 HMO and other (see instructions)				50			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	378	54	929		14.00
15.00 CAH visits							15.00
16.00 SUBPROVIDER - IPF							16.00
17.00 SUBPROVIDER - IRF							17.00
18.00 SUBPROVIDER	0.00	0	0	0	0	0	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	0.00						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)							23.00
24.00 HOSPICE	0.00						24.00
24.10 HOSPICE (non-distinct part)							24.10
25.00 CMHC - CMHC							25.00
26.00 RURAL HEALTH CLINIC							26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER							26.25
27.00 Total (sum of lines 14-26)	0.00						27.00
28.00 Observation Bed Days							28.00
29.00 Ambulance Trips							29.00
30.00 Employee discount days (see instruction)							30.00
31.00 Employee discount days - IRF							31.00
32.00 Labor & delivery days (see instructions)							32.00
33.00 LTCH non-covered days							33.00

					1.00	
Uncompensated and indigent care cost computation						
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)				0.306619	1.00
Medicaid (see instructions for each line)						
2.00	Net revenue from Medicaid				0	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?				Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?				N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid				1,214,089	5.00
6.00	Medicaid charges				15,036,083	6.00
7.00	Medicaid cost (line 1 times line 6)				4,610,349	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)				3,396,260	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				32,944	18.00
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)				3,396,260	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	7,389,874	45,388	7,435,262	20.00	
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	2,265,876	13,917	2,279,793	21.00	
22.00	Partial payment by patients approved for charity care	0	0	0	22.00	
23.00	Cost of charity care (line 21 minus line 22)	2,265,876	13,917	2,279,793	23.00	
					1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?					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)				1,737,120	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)				547,504	27.00
28.00	Non-Medicare and Non-Reimbursable Medicare bad debt expense (line 26 minus line 27)				1,189,616	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)				364,759	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)				2,644,552	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)				6,040,812	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES			Provider CCN: 151301	Period: From 07/01/2012 To 06/30/2013	Worksheet A	Date/Time Prepared: 11/25/2013 3:32 pm
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	CAP REL COSTS-BLDG & FIXT		1,134,252	1,134,252	0	1,134,252 1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		309,978	309,978	0	309,978 2.00
3.00 00300	OTHER CAP REL COSTS		0	0	0	0 3.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	197,038	2,849,335	3,046,373	0	3,046,373 4.00
5.00 00500	ADMINISTRATIVE & GENERAL	1,915,422	2,781,759	4,697,181	-220	4,696,961 5.00
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	0 6.00
7.00 00700	OPERATION OF PLANT	260,979	1,095,986	1,356,965	0	1,356,965 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	62,610	62,610	0	62,610 8.00
9.00 00900	HOUSEKEEPING	0	413,043	413,043	0	413,043 9.00
10.00 01000	DIETARY	9,362	513,538	522,900	-378,957	143,943 10.00
11.00 01100	CAFETERIA	0	0	0	378,953	378,953 11.00
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0 12.00
13.00 01300	NURSING ADMINISTRATION	919,224	71,123	990,347	-163	990,184 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	91,358	5,037	96,395	-341	96,054 14.00
15.00 01500	PHARMACY	264,876	741,158	1,006,034	-867	1,005,167 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	207,534	68,141	275,675	0	275,675 16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	0 17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	2,066,938	409,905	2,476,843	-653,338	1,823,505 30.00
42.00 04200	SUBPROVIDER	0	0	0	0	0 42.00
43.00 04300	NURSERY	0	0	0	232,084	232,084 43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	399,831	783,241	1,183,072	-96,637	1,086,435 50.00
51.00 05100	RECOVERY ROOM	0	0	0	0	0 51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	383,242	383,242 52.00
53.00 05300	ANESTHESIOLOGY	592,000	132,179	724,179	0	724,179 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	613,912	126,754	740,666	-1,461	739,205 54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0 55.00
56.00 05600	RADIOISOTOPE	0	0	0	0	0 56.00
57.00 05700	CT SCAN	31,917	41,681	73,598	-483	73,115 57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	46,436	242,124	288,560	-116	288,444 58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0 59.00
60.00 06000	LABORATORY	116,949	1,510,670	1,627,619	-6,198	1,621,421 60.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0 64.00
65.00 06500	RESPIRATORY THERAPY	457,704	34,700	492,404	-100,712	391,692 65.00
65.01 03950	SLEEP LAB	0	54,419	54,419	0	54,419 65.01
66.00 06600	PHYSICAL THERAPY	351,714	47,740	399,454	-1,790	397,664 66.00
67.00 06700	OCCUPATIONAL THERAPY	55,228	24	55,252	0	55,252 67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	0 68.00
69.00 06900	ELECTROCARDIOLOGY	46,178	13,656	59,834	94,491	154,325 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	3,320	3,320	0	3,320 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	71,494	71,494	187,487	258,981 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	67,967	67,967	0	67,967 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	155,652	27,106	182,758	-4,265	178,493 73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	0 74.00
75.00 07500	ASC (NON-DISTINCT PART)	0	0	0	0	0 75.00
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	802,891	1,454,818	2,257,709	-27,909	2,229,800 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0 92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100	HOME HEALTH AGENCY	0	0	0	0	0 101.00
SPECIAL PURPOSE COST CENTERS						
116.00 11600	HOSPICE	0	0	0	0	0 116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	9,603,143	15,067,758	24,670,901	2,800	24,673,701 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0 190.00
191.00 19100	RESEARCH	0	0	0	0	0 191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	35,446	3,651	39,097	-43	39,054 192.00
193.00 19300	NONPAID WORKERS	0	0	0	0	0 193.00
194.00 07950	OTHER NRCC - PUBLIC RELATIONS	0	696	696	0	696 194.00
194.01 07951	OTHER NRCC - FOUNDATION	46,472	88,143	134,615	-1,185	133,430 194.01
194.02 07952	OTHER NRCC - GRANTS	17,655	67,531	85,186	-1,572	83,614 194.02
200.00	TOTAL (SUM OF LINES 118-199)	9,702,716	15,227,779	24,930,495	0	24,930,495 200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151301

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

worksheet A

Date/Time Prepared:
11/25/2013 3:32 pm

Cost Center Description			Adjustments (See A-8) 6.00	Net Expenses For Allocation 7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-546,685	587,567	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-25,425	284,553	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	189,268	3,235,641	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	431,421	5,128,382	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700	OPERATION OF PLANT	-16,466	1,340,499	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	62,610	8.00
9.00	00900	HOUSEKEEPING	0	413,043	9.00
10.00	01000	DIETARY	0	143,943	10.00
11.00	01100	CAFETERIA	-93,150	285,803	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	990,184	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	96,054	14.00
15.00	01500	PHARMACY	-585	1,004,582	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-6,364	269,311	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-537,554	1,285,951	30.00
42.00	04200	SUBPROVIDER	0	0	42.00
43.00	04300	NURSERY	0	232,084	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	1,086,435	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	383,242	52.00
53.00	05300	ANESTHESIOLOGY	-649,034	75,145	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-20	739,185	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	73,115	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	288,444	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	1,621,421	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	391,692	65.00
65.01	03950	SLEEP LAB	0	54,419	65.01
66.00	06600	PHYSICAL THERAPY	-6,610	391,054	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	55,252	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	154,325	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	3,320	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	258,981	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	67,967	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	178,493	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	75.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	-150,000	2,079,800	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	0	101.00
SPECIAL PURPOSE COST CENTERS					
116.00	11600	HOSPICE	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-1,411,204	23,262,497	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
191.00	19100	RESEARCH	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	39,054	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
194.00	07950	OTHER NRCC - PUBLIC RELATIONS	207,527	208,223	194.00
194.01	07951	OTHER NRCC - FOUNDATION	0	133,430	194.01
194.02	07952	OTHER NRCC - GRANTS	0	83,614	194.02
200.00		TOTAL (SUM OF LINES 118-199)	-1,203,677	23,726,818	200.00

COST CENTERS USED IN COST REPORT		Provider CCN: 151301	Period: From 07/01/2012 To 06/30/2013	Worksheet Non-CMS W Date/Time Prepared: 11/25/2013 3:32 pm
Cost Center Description		CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	00100		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	00200		2.00
3.00	OTHER CAP REL COSTS	00300		3.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	00400		4.00
5.00	ADMINISTRATIVE & GENERAL	00500		5.00
6.00	MAINTENANCE & REPAIRS	00600		6.00
7.00	OPERATION OF PLANT	00700		7.00
8.00	LAUNDRY & LINEN SERVICE	00800		8.00
9.00	HOUSEKEEPING	00900		9.00
10.00	DIETARY	01000		10.00
11.00	CAFETERIA	01100		11.00
12.00	MAINTENANCE OF PERSONNEL	01200		12.00
13.00	NURSING ADMINISTRATION	01300		13.00
14.00	CENTRAL SERVICES & SUPPLY	01400		14.00
15.00	PHARMACY	01500		15.00
16.00	MEDICAL RECORDS & LIBRARY	01600		16.00
17.00	SOCIAL SERVICE	01700		17.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	03000		30.00
42.00	SUBPROVIDER	04200		42.00
43.00	NURSERY	04300		43.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	05000		50.00
51.00	RECOVERY ROOM	05100		51.00
52.00	DELIVERY ROOM & LABOR ROOM	05200		52.00
53.00	ANESTHESIOLOGY	05300		53.00
54.00	RADIOLOGY-DIAGNOSTIC	05400		54.00
55.00	RADIOLOGY-THERAPEUTIC	05500		55.00
56.00	RADIOISOTOPE	05600		56.00
57.00	CT SCAN	05700		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	05800		58.00
59.00	CARDIAC CATHETERIZATION	05900		59.00
60.00	LABORATORY	06000		60.00
64.00	INTRAVENOUS THERAPY	06400		64.00
65.00	RESPIRATORY THERAPY	06500		65.00
65.01	SLEEP LAB	03950		65.01
66.00	PHYSICAL THERAPY	06600		66.00
67.00	OCCUPATIONAL THERAPY	06700		67.00
68.00	SPEECH PATHOLOGY	06800		68.00
69.00	ELECTROCARDIOLOGY	06900		69.00
70.00	ELECTROENCEPHALOGRAPHY	07000		70.00
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
74.00	RENAL DIALYSIS	07400		74.00
75.00	ASC (NON-DISTINCT PART)	07500		75.00
OUTPATIENT SERVICE COST CENTERS				
91.00	EMERGENCY	09100		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	09200		92.00
OTHER REIMBURSABLE COST CENTERS				
101.00	HOME HEALTH AGENCY	10100		101.00
SPECIAL PURPOSE COST CENTERS				
116.00	HOSPICE	11600		116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)			118.00
NONREIMBURSABLE COST CENTERS				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	19000		190.00
191.00	RESEARCH	19100		191.00
192.00	PHYSICIANS' PRIVATE OFFICES	19200		192.00
193.00	NONPAID WORKERS	19300		193.00
194.00	OTHER NRCC - PUBLIC RELATIONS	07950		194.00
194.01	OTHER NRCC - FOUNDATION	07951		194.01
194.02	OTHER NRCC - GRANTS	07952		194.02
200.00	TOTAL (SUM OF LINES 118-199)			200.00

RECLASSIFICATIONS

Provider CCN: 151301

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

Worksheet A-6

Date/Time Prepared:
11/25/2013 3:32 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
A - CAFETERIA					
1.00	CAFETERIA	11.00	6,785	372,168	1.00
	TOTALS		6,785	372,168	
B - EKG					
1.00	ELECTROCARDIOLOGY	69.00	88,366	6,699	1.00
	TOTALS		88,366	6,699	
C - NURSERY RECLASS					
1.00	NURSERY	43.00	184,706	47,378	1.00
	TOTALS		184,706	47,378	
F - LDR RECLASS					
1.00	DELIVERY ROOM & LABOR ROOM	52.00	305,007	78,235	1.00
	TOTALS		305,007	78,235	
G - MEDICAL SUPPLIES RECLASS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	187,487	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
	TOTALS		0	187,487	
500.00	Grand Total: Increases		584,864	691,967	500.00

RECLASSIFICATIONS	Provider CCN: 151301	Period: From 07/01/2012 To 06/30/2013	Worksheet A-6 Date/Time Prepared: 11/25/2013 3:32 pm
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		Decreases				
	Cost Center	Line #	Salary	Other	wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
A - CAFETERIA						
1.00	DIETARY	10.00	6,785	372,168	0	1.00
	TOTALS		6,785	372,168		
B - EKG						
1.00	RESPIRATORY THERAPY	65.00	88,366	6,699	0	1.00
	TOTALS		88,366	6,699		
C - NURSERY RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	184,706	47,378	0	1.00
	TOTALS		184,706	47,378		
F - LDR RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	305,007	78,235	0	1.00
	TOTALS		305,007	78,235		
G - MEDICAL SUPPLIES RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	220	0	1.00
2.00	DIETARY	10.00	0	4	0	2.00
3.00	NURSING ADMINISTRATION	13.00	0	163	0	3.00
4.00	CENTRAL SERVICES & SUPPLY	14.00	0	341	0	4.00
5.00	PHARMACY	15.00	0	867	0	5.00
6.00	ADULTS & PEDIATRICS	30.00	0	38,012	0	6.00
7.00	OPERATING ROOM	50.00	0	96,637	0	7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,461	0	8.00
9.00	CT SCAN	57.00	0	483	0	9.00
10.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	116	0	10.00
11.00	LABORATORY	60.00	0	6,198	0	11.00
12.00	RESPIRATORY THERAPY	65.00	0	5,647	0	12.00
13.00	PHYSICAL THERAPY	66.00	0	1,790	0	13.00
14.00	ELECTROCARDIOLOGY	69.00	0	574	0	14.00
15.00	DRUGS CHARGED TO PATIENTS	73.00	0	4,265	0	15.00
16.00	EMERGENCY	91.00	0	27,909	0	16.00
17.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	43	0	17.00
18.00	OTHER NRCC - FOUNDATION	194.01	0	1,185	0	18.00
19.00	OTHER NRCC - GRANTS	194.02	0	1,572	0	19.00
	TOTALS		0	187,487		
500.00	Grand Total: Decreases		584,864	691,967		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 - CAFETERIA							
1.00	CAFETERIA	11.00	6,785	DIETARY	10.00	6,785	1.00
	TOTALS		6,785	TOTALS		6,785	
B - EKG							
1.00	ELECTROCARDIOLOGY	69.00	88,366	RESPIRATORY THERAPY	65.00	88,366	1.00
	TOTALS		88,366	TOTALS		88,366	
C - NURSERY RECLASS							
1.00	NURSERY	43.00	184,706	ADULTS & PEDIATRICS	30.00	184,706	1.00
	TOTALS		184,706	TOTALS		184,706	
F - LDR RECLASS							
1.00	DELIVERY ROOM & LABOR ROOM	52.00	305,007	ADULTS & PEDIATRICS	30.00	305,007	1.00
	TOTALS		305,007	TOTALS		305,007	
G - MEDICAL SUPPLIES RECLASS							
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	ADMINISTRATIVE & GENERAL	5.00	0	1.00
2.00		0.00	0	DIETARY	10.00	0	2.00
3.00		0.00	0	NURSING ADMINISTRATION	13.00	0	3.00
4.00		0.00	0	CENTRAL SERVICES & SUPPLY	14.00	0	4.00
5.00		0.00	0	PHARMACY	15.00	0	5.00
6.00		0.00	0	ADULTS & PEDIATRICS	30.00	0	6.00
7.00		0.00	0	OPERATING ROOM	50.00	0	7.00
8.00		0.00	0	RADIOLOGY-DIAGNOSTIC	54.00	0	8.00
9.00		0.00	0	CT SCAN	57.00	0	9.00
10.00		0.00	0	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	10.00
11.00		0.00	0	LABORATORY	60.00	0	11.00
12.00		0.00	0	RESPIRATORY THERAPY	65.00	0	12.00
13.00		0.00	0	PHYSICAL THERAPY	66.00	0	13.00
14.00		0.00	0	ELECTROCARDIOLOGY	69.00	0	14.00
15.00		0.00	0	DRUGS CHARGED TO PATIENTS	73.00	0	15.00
16.00		0.00	0	EMERGENCY	91.00	0	16.00
17.00		0.00	0	PHYSICIANS' PRIVATE OFFICES	192.00	0	17.00
18.00		0.00	0	OTHER NRCC - FOUNDATION	194.01	0	18.00
19.00		0.00	0	OTHER NRCC - GRANTS	194.02	0	19.00
	TOTALS		0	TOTALS		0	
500.00	Grand Total: Increases		584,864	Grand Total: Decreases		584,864	500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151301

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

Worksheet A-7
Part I
Date/Time Prepared:
11/25/2013 3:32 pm

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	696,652	0	0	0	1.00
2.00	Land Improvements	25,100	0	0	0	2.00
3.00	Buildings and Fixtures	18,048,925	0	0	0	3.00
4.00	Building Improvements	0	0	0	0	4.00
5.00	Fixed Equipment	503,967	0	0	22,589	5.00
6.00	Movable Equipment	5,459,910	70,496	0	70,496	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	24,734,554	70,496	0	70,496	22,589
9.00	Reconciling Items	0	0	0	0	0
10.00	Total (line 8 minus line 9)	24,734,554	70,496	0	70,496	22,589
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	696,652	0			1.00
2.00	Land Improvements	25,100	0			2.00
3.00	Buildings and Fixtures	18,048,925	0			3.00
4.00	Building Improvements	0	0			4.00
5.00	Fixed Equipment	481,378	0			5.00
6.00	Movable Equipment	5,530,406	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	24,782,461	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	24,782,461	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151301

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

Worksheet A-7
Part II
Date/Time Prepared:
11/25/2013 3:32 pm

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	1,134,252	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	309,978	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,444,230	0	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	1,134,252		1.00		
2.00	CAP REL COSTS-MVBLE EQUIP	0	309,978		2.00		
3.00	Total (sum of lines 1-2)	0	1,444,230		3.00		

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151301

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

Worksheet A-7
Part III
Date/Time Prepared:
11/25/2013 3:32 pm

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	19,252,055	0	19,252,055	0.776842	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	5,530,406	0	5,530,406	0.223158	0	2.00
3.00	Total (sum of lines 1-2)	24,782,461	0	24,782,461	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	587,567	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	284,553	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	872,120	0	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	0	0	0	0	587,567	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	284,553	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	872,120	3.00

Line #	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	
				3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	A	-254,622	CAP REL COSTS-BLDG & FIXT	1.00		9 1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00		0 2.00
3.00	Investment income - other (chapter 2)	A	-37,818	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	-1,335,673				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	1,659,632				0 12.00
13.00	Laundry and linen service		0		0.00		0 13.00
14.00	Cafeteria-employees and guests	B	-93,150	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		0		0.00		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	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00		0 32.00
33.00	PROVIDER ASSESSMENT TAX ADJUSTMENT	A	-955,712	ADMINISTRATIVE & GENERAL	5.00		0 33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 151301

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

Worksheet A-8

Date/Time Prepared:
11/25/2013 3:32 pm

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
33.01	LOSS ON SALE OF ASSETS	A	-25,425	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.01
33.02	OTHER OPERATING INCOME	B	-5,121	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	OTHER PLANT OPERATION REVENUE	B	-22,939	OPERATION OF PLANT	7.00	0	33.03
33.04	OTHER PHARMACY REVENUE	B	-585	PHARMACY	15.00	0	33.04
33.05	OTHER HIM REVENUE	B	-6,364	MEDICAL RECORDS & LIBRARY	16.00	0	33.05
33.06	OTHER OPERATING REVENUE	B	-2,156	ADULTS & PEDIATRICS	30.00	0	33.06
33.07	OTHER ANESTHESIOLOGY REVENUE	B	-19	ANESTHESIOLOGY	53.00	0	33.07
33.08	OTHER RADIOLOGY REVENUE	B	-20	RADIOLOGY-DIAGNOSTIC	54.00	0	33.08
33.09	OTHER PHYSICAL THERAPY REVENUE	B	-5,350	PHYSICAL THERAPY	66.00	9	33.09
33.10	DONATIONS	A	-10,500	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	AHA & IHA DUES	A	-680	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.13	PAVILION DEPRECIATION	A	-2,507	CAP REL COSTS-BLDG & FIXT	1.00	9	33.13
33.14	CARRYFORWARD	A	-104,668	CAP REL COSTS-BLDG & FIXT	1.00	9	33.14
33.16			0		0.00	0	33.16
33.17			0		0.00	0	33.17
33.18			0		0.00	0	33.18
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,203,677				50.00

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS
 Provider CCN: 151301
 Period: From 07/01/2012 To 06/30/2013
 Worksheet A-8-1
 Date/Time Prepared: 11/25/2013 3:32 pm

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED					
HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	3,015,862	1,426,510 1.00
2.00	4.00	EMPLOYEE BENEFITS	HOME OFFICE	94,961	94,961 2.00
3.00	194.00	OTHER NRCC - PUBLIC RELATIONS	HOME OFFICE	207,527	0 3.00
4.00	4.00	EMPLOYEE BENEFITS	ST. VINCENT HLTH CHARGEBACK	249,511	249,511 4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	ST. VINCENT HLTH CHARGEBACK	936,827	936,827 4.01
4.02	9.00	HOUSEKEEPING	ST. VINCENT HLTH CHARGEBACK	-60,256	-60,256 4.02
4.03	14.00	CENTRAL SERVICES & SUPPLY	ST. VINCENT HLTH CHARGEBACK	78,500	78,500 4.03
4.04	15.00	PHARMACY	ST. VINCENT HLTH CHARGEBACK	-139,558	-139,558 4.04
4.05	16.00	MEDICAL RECORDS & LIBRARY	ST. VINCENT HLTH CHARGEBACK	152,616	152,616 4.05
4.06	30.00	ADULTS & PEDIATRICS	ST. VINCENT HLTH CHARGEBACK	3,979	3,979 4.06
4.07	53.00	ANESTHESIOLOGY	ST. VINCENT HLTH CHARGEBACK	4,916	4,916 4.07
4.08	54.00	RADIOLOGY-DIAGNOSTIC	ST. VINCENT HLTH CHARGEBACK	95,213	95,213 4.08
4.09	71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	ST. VINCENT HLTH CHARGEBACK	1,752	1,752 4.09
4.10	91.00	EMERGENCY	ST. VINCENT HLTH CHARGEBACK	11	11 4.10
4.11	4.00	EMPLOYEE BENEFITS	SELF INSURANCE	1,501,490	1,312,222 4.11
4.12	1.00	CAP REL COSTS-BLDG & FIXT	ASCENSION INTEREST	254,622	439,510 4.12
4.13	5.00	ADMINISTRATIVE & GENERAL	ASCENSION INTEREST	37,818	65,278 4.13
4.14	7.00	OPERATION OF PLANT	TRIMEDX	454,596	448,123 4.14
4.15	4.00	EMPLOYEE BENEFITS	ASCENSION PENSION	273,734	273,734 4.15
4.16	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE - EXEC OFFSET	0	120,640 4.16
4.17	0.00			0	0 4.17
4.18	0.00			0	0 4.18
4.19	0.00			0	0 4.19
4.20	0.00			0	0 4.20
5.00	0			7,164,121	5,504,489 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	G	ST. VINCENT HTH	100.00	ST. VINCENT HTH	100.00	6.00
7.00	G	ASCENSION	100.00	ASCENSION	100.00	7.00
8.00	B	ST. VINCENT HSP	100.00	ST. VINCENT HSP	100.00	8.00
9.00	A	TRIMEDX	0.00	TRIMEDX	0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:	HOME OFFICE				100.00

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

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

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

Provider CCN: 151301

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

Worksheet A-8-1

Date/Time Prepared:
11/25/2013 3:32 pm

	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	1,589,352	9	1.00
2.00	0	9	2.00
3.00	207,527	9	3.00
4.00	0	0	4.00
4.01	0	0	4.01
4.02	0	0	4.02
4.03	0	0	4.03
4.04	0	0	4.04
4.05	0	0	4.05
4.06	0	0	4.06
4.07	0	0	4.07
4.08	0	0	4.08
4.09	0	0	4.09
4.10	0	0	4.10
4.11	189,268	0	4.11
4.12	-184,888	9	4.12
4.13	-27,460	0	4.13
4.14	6,473	0	4.14
4.15	0	0	4.15
4.16	-120,640	0	4.16
4.17	0	0	4.17
4.18	0	0	4.18
4.19	0	0	4.19
4.20	0	0	4.20
5.00	1,659,632		5.00

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

	Related Organization(s) and/or Home Office	
	Type of Business	
	6.00	

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

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

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

6.00	ADMINISTRATION	6.00
7.00	ADMINISTRATION	7.00
8.00	HOSPITAL	8.00
9.00	TECHNOLOGY MGMT	9.00
10.00		10.00
100.00		100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151301

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

Worksheet A-8-2

Date/Time Prepared:
11/25/2013 3:32 pm

	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	30.00	ADULTS & PEDIATRICS	535,398	535,398	0	0	0	1.00
2.00	53.00	ANESTHESIOLOGY	649,015	649,015	0	0	0	2.00
3.00	66.00	PHYSICAL THERAPY	1,260	1,260	0	0	0	3.00
4.00	91.00	EMERGENCY	1,276,299	150,000	1,126,299	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			2,461,972	1,335,673	1,126,299		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	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	2.00
3.00	66.00	PHYSICAL THERAPY	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	30.00	ADULTS & PEDIATRICS	0	0	0	535,398	1.00
2.00	53.00	ANESTHESIOLOGY	0	0	0	649,015	2.00
3.00	66.00	PHYSICAL THERAPY	0	0	0	1,260	3.00
4.00	91.00	EMERGENCY	0	0	0	150,000	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	1,335,673	200.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 151301	Period: From 07/01/2012 To 06/30/2013	Worksheet B Part I Date/Time Prepared: 11/25/2013 3:32 pm			
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal		
		BLDG & FIXT	MVBLE EQUIP				
	0	1.00	2.00	4.00	4A		
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	587,567	587,567			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	284,553		284,553		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,235,641	0	0	3,235,641	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,128,382	92,430	44,763	728,031	5,993,606
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	1,340,499	35,109	17,003	99,195	1,491,806
8.00	00800	LAUNDRY & LINEN SERVICE	62,610	4,793	2,321	0	69,724
9.00	00900	HOUSEKEEPING	413,043	4,493	2,176	0	419,712
10.00	01000	DIETARY	143,943	16,671	8,073	979	169,666
11.00	01100	CAFETERIA	285,803	3,924	1,900	2,579	294,206
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	990,184	1,078	522	349,386	1,341,170
14.00	01400	CENTRAL SERVICES & SUPPLY	96,054	0	0	34,724	130,778
15.00	01500	PHARMACY	1,004,582	0	0	100,676	1,105,258
16.00	01600	MEDICAL RECORDS & LIBRARY	269,311	11,106	5,379	78,881	364,677
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,285,951	78,897	38,209	426,590	1,829,647
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
43.00	04300	NURSERY	232,084	936	453	70,205	303,678
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,086,435	57,853	28,018	151,971	1,324,277
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	383,242	17,592	8,520	115,930	525,284
53.00	05300	ANESTHESIOLOGY	75,145	0	0	21,030	96,175
54.00	05400	RADIOLOGY-DIAGNOSTIC	739,185	46,604	22,570	233,341	1,041,700
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	73,115	0	0	12,131	85,246
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	288,444	0	0	17,650	306,094
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	1,621,421	13,053	6,322	44,451	1,685,247
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	391,692	9,504	4,602	140,381	546,179
65.01	03950	SLEEP LAB	54,419	509	247	0	55,175
66.00	06600	PHYSICAL THERAPY	391,054	20,131	9,749	133,203	554,137
67.00	06700	OCCUPATIONAL THERAPY	55,252	4,748	2,299	20,992	83,291
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	154,325	0	0	51,139	205,464
70.00	07000	ELECTROENCEPHALOGRAPHY	3,320	0	0	0	3,320
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	258,981	12,604	6,104	0	277,689
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	67,967	0	0	0	67,967
73.00	07300	DRUGS CHARGED TO PATIENTS	178,493	5,482	2,655	59,161	245,791
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	2,079,800	31,821	15,411	305,169	2,432,201
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	HOSPICE	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	23,262,497	469,338	227,296	3,197,795	23,049,165
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	959	464	0	1,423
191.00	19100	RESEARCH	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	39,054	116,282	56,315	13,473	225,124
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
194.00	07950	OTHER NRCC - PUBLIC RELATIONS	208,223	494	239	0	208,956
194.01	07951	OTHER NRCC - FOUNDATION	133,430	494	239	17,663	151,826
194.02	07952	OTHER NRCC - GRANTS	83,614	0	0	6,710	90,324
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	23,726,818	587,567	284,553	3,235,641	23,726,818

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151301

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

Worksheet B
Part I
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Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500	5,993,606					5.00
6.00	00600	0	0				6.00
7.00	00700	504,213		1,996,019			7.00
8.00	00800	23,566		20,796	114,086		8.00
9.00	00900	141,858		19,496	0	581,066	9.00
10.00	01000	57,345		72,332	0	21,491	10.00
11.00	01100	99,438		17,027	0	5,059	11.00
12.00	01200	0	0	0	0	0	12.00
13.00	01300	453,299		4,679	0	1,390	13.00
14.00	01400	44,201		0	0	0	14.00
15.00	01500	373,564		0	0	0	15.00
16.00	01600	123,256		48,189	0	14,317	16.00
17.00	01700	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	618,399	0	342,326	41,263	101,709	30.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	102,640	0	4,062	0	1,207	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	447,590	0	251,017	13,411	74,580	50.00
51.00	05100	0	0	0	0	0	51.00
52.00	05200	177,540	0	76,329	0	22,678	52.00
53.00	05300	32,506	0	0	0	0	53.00
54.00	05400	352,082	0	202,211	13,352	60,079	54.00
55.00	05500	0	0	0	0	0	55.00
56.00	05600	0	0	0	0	0	56.00
57.00	05700	28,812	0	0	0	0	57.00
58.00	05800	103,456	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	569,593	0	56,637	0	16,828	60.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	184,602	0	41,235	0	12,251	65.00
65.01	03950	18,648	0	2,210	0	656	65.01
66.00	06600	187,292	0	87,344	0	25,951	66.00
67.00	06700	28,151	0	20,601	0	6,121	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	69,444	0	0	0	0	69.00
70.00	07000	1,122	0	0	0	0	70.00
71.00	07100	93,856	0	54,688	0	16,248	71.00
72.00	07200	22,972	0	0	0	0	72.00
73.00	07300	83,074	0	23,786	0	7,067	73.00
74.00	07400	0	0	0	0	0	74.00
75.00	07500	0	0	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	822,049	0	138,068	46,060	41,021	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	0	0	0	0	0	116.00
118.00		5,764,568	0	1,483,033	114,086	428,653	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	481	0	4,159	0	1,236	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	76,089	0	504,537	0	149,903	192.00
193.00	19300	0	0	0	0	0	193.00
194.00	07950	70,625	0	2,145	0	637	194.00
194.01	07951	51,315	0	2,145	0	637	194.01
194.02	07952	30,528	0	0	0	0	194.02
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		5,993,606	0	1,996,019	114,086	581,066	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151301

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

Worksheet B
Part I
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Cost Center Description		DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
		10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	320,834					10.00
11.00	01100	0	415,730				11.00
12.00	01200	0	0	0			12.00
13.00	01300	0	53,881	0	1,854,419		13.00
14.00	01400	0	9,002	0	0	183,981	14.00
15.00	01500	0	9,954	0	0	0	15.00
16.00	01600	0	24,115	0	0	0	16.00
17.00	01700	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	320,834	84,192	0	929,042	0	30.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	10,492	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	23,447	0	258,734	0	50.00
51.00	05100	0	0	0	0	0	51.00
52.00	05200	0	17,324	0	0	0	52.00
53.00	05300	0	513	0	0	0	53.00
54.00	05400	0	37,817	0	0	0	54.00
55.00	05500	0	0	0	0	0	55.00
56.00	05600	0	0	0	0	0	56.00
57.00	05700	0	2,176	0	0	0	57.00
58.00	05800	0	2,693	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	0	10,528	0	0	0	60.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	0	22,733	0	0	0	65.00
65.01	03950	0	0	0	0	0	65.01
66.00	06600	0	22,607	0	0	0	66.00
67.00	06700	0	2,867	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	0	8,198	0	0	0	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	145,734	71.00
72.00	07200	0	0	0	0	38,247	72.00
73.00	07300	0	8,606	0	0	0	73.00
74.00	07400	0	0	0	0	0	74.00
75.00	07500	0	0	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	0	56,622	0	624,808	0	91.00
92.00	09200	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	0	0	0	0	0	116.00
118.00		320,834	407,767	0	1,812,584	183,981	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	0	3,791	0	41,835	0	192.00
193.00	19300	0	0	0	0	0	193.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	3,066	0	0	0	194.01
194.02	07952	0	1,106	0	0	0	194.02
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		320,834	415,730	0	1,854,419	183,981	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151301

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

Worksheet B
Part I
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Cost Center Description		PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		15.00	16.00	17.00	24.00	25.00	
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
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
12.00	01200	MAINTENANCE OF PERSONNEL					12.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY	1,488,776				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	574,554			16.00
17.00	01700	SOCIAL SERVICE	0	0	0		17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	39,499	0	4,306,911	30.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
43.00	04300	NURSERY	0	5,344	0	427,423	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	54,964	0	2,448,020	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	8,825	0	827,980	52.00
53.00	05300	ANESTHESIOLOGY	0	4,431	0	133,625	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	63,975	0	1,771,216	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	92,650	0	208,884	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	23,350	0	435,593	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	131,388	0	2,470,221	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	15,850	0	822,850	65.00
65.01	03950	SLEEP LAB	0	3,316	0	80,005	65.01
66.00	06600	PHYSICAL THERAPY	0	16,203	0	893,534	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,814	0	143,845	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	7,795	0	290,901	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	962	0	5,404	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	588,215	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	129,186	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,488,776	0	0	1,857,100	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0	103,188	0	4,264,017	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	HOSPICE	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,488,776	574,554	0	22,104,930	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	7,299	190.00
191.00	19100	RESEARCH	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	1,001,279	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
194.00	07950	OTHER NRCC - PUBLIC RELATIONS	0	0	0	282,363	194.00
194.01	07951	OTHER NRCC - FOUNDATION	0	0	0	208,989	194.01
194.02	07952	OTHER NRCC - GRANTS	0	0	0	121,958	194.02
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,488,776	574,554	0	23,726,818	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151301

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

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Part I
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Cost Center Description		Total	
		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
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	12.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	4,306,911
42.00	04200	SUBPROVIDER	0
43.00	04300	NURSERY	427,423
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	2,448,020
51.00	05100	RECOVERY ROOM	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	827,980
53.00	05300	ANESTHESIOLOGY	133,625
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,771,216
55.00	05500	RADIOLOGY-THERAPEUTIC	0
56.00	05600	RADIOISOTOPE	0
57.00	05700	CT SCAN	208,884
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	435,593
59.00	05900	CARDIAC CATHETERIZATION	0
60.00	06000	LABORATORY	2,470,221
64.00	06400	INTRAVENOUS THERAPY	0
65.00	06500	RESPIRATORY THERAPY	822,850
65.01	03950	SLEEP LAB	80,005
66.00	06600	PHYSICAL THERAPY	893,534
67.00	06700	OCCUPATIONAL THERAPY	143,845
68.00	06800	SPEECH PATHOLOGY	0
69.00	06900	ELECTROCARDIOLOGY	290,901
70.00	07000	ELECTROENCEPHALOGRAPHY	5,404
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	588,215
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	129,186
73.00	07300	DRUGS CHARGED TO PATIENTS	1,857,100
74.00	07400	RENAL DIALYSIS	0
75.00	07500	ASC (NON-DISTINCT PART)	0
OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	4,264,017
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0
OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	0
SPECIAL PURPOSE COST CENTERS			
116.00	11600	HOSPICE	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	22,104,930
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	7,299
191.00	19100	RESEARCH	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,001,279
193.00	19300	NONPAID WORKERS	0
194.00	07950	OTHER NRCC - PUBLIC RELATIONS	282,363
194.01	07951	OTHER NRCC - FOUNDATION	208,989
194.02	07952	OTHER NRCC - GRANTS	121,958
200.00		Cross Foot Adjustments	0
201.00		Negative Cost Centers	0
202.00		TOTAL (sum lines 118-201)	23,726,818

COST ALLOCATION STATISTICS

Provider CCN: 151301

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

Worksheet Non-CMS W

Date/Time Prepared:
11/25/2013 3:32 pm

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	3	GROSS SALARIES	4.00
5.00	ADMINISTRATIVE & GENERAL	-5	ACCUM. COST	5.00
6.00	MAINTENANCE & REPAIRS	24	ASSIGNED TIME	6.00
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	19	HOURS	11.00
12.00	MAINTENANCE OF PERSONNEL	12	NUMBER HOUSED	12.00
13.00	NURSING ADMINISTRATION	13	DIRECT NURS. HRS.	13.00
14.00	CENTRAL SERVICES & SUPPLY	14	COSTED REQUIS.	14.00
15.00	PHARMACY	15	COSTED REQUIS.	15.00
16.00	MEDICAL RECORDS & LIBRARY	16	GROSS CHARGES	16.00
17.00	SOCIAL SERVICE	17	TIME SPENT	17.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151301

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

Worksheet B
Part II
Date/Time Prepared:
11/25/2013 3:32 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	2A	4.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	357,501	92,430	44,763	494,694	5.00
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00 00700	OPERATION OF PLANT	0	35,109	17,003	52,112	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	4,793	2,321	7,114	8.00
9.00 00900	HOUSEKEEPING	0	4,493	2,176	6,669	9.00
10.00 01000	DIETARY	0	16,671	8,073	24,744	10.00
11.00 01100	CAFETERIA	0	3,924	1,900	5,824	11.00
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00 01300	NURSING ADMINISTRATION	0	1,078	522	1,600	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00 01500	PHARMACY	42,005	0	0	42,005	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	2,593	11,106	5,379	19,078	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	69,395	78,897	38,209	186,501	30.00
42.00 04200	SUBPROVIDER	0	0	0	0	42.00
43.00 04300	NURSERY	0	936	453	1,389	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	44,165	57,853	28,018	130,036	50.00
51.00 05100	RECOVERY ROOM	0	0	0	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	17,592	8,520	26,112	52.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	46,604	22,570	69,174	54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
56.00 05600	RADIOISOTOPE	0	0	0	0	56.00
57.00 05700	CT SCAN	0	0	0	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	241,374	0	0	241,374	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00 06000	LABORATORY	1,820	13,053	6,322	21,195	60.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	1,167	9,504	4,602	15,273	65.00
65.01 03950	SLEEP LAB	280	509	247	1,036	65.01
66.00 06600	PHYSICAL THERAPY	4,197	20,131	9,749	34,077	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	4,748	2,299	7,047	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	12,604	6,104	18,708	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	5,482	2,655	8,137	73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	74.00
75.00 07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	3,980	31,821	15,411	51,212	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
116.00 11600	HOSPICE	0	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	768,477	469,338	227,296	1,465,111	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	959	464	1,423	190.00
191.00 19100	RESEARCH	0	0	0	0	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	448	116,282	56,315	173,045	192.00
193.00 19300	NONPAID WORKERS	0	0	0	0	193.00
194.00 07950	OTHER NRCC - PUBLIC RELATIONS	0	494	239	733	194.00
194.01 07951	OTHER NRCC - FOUNDATION	0	494	239	733	194.01
194.02 07952	OTHER NRCC - GRANTS	0	0	0	0	194.02
200.00	Cross Foot Adjustments	0	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	768,925	587,567	284,553	1,641,045	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151301

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

Worksheet B
Part II
Date/Time Prepared:
11/25/2013 3:32 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500	494,694					5.00
6.00	00600	0	0				6.00
7.00	00700	41,615	0	93,727			7.00
8.00	00800	1,945	0	977	10,036		8.00
9.00	00900	11,708	0	915	0	19,292	9.00
10.00	01000	4,733	0	3,396	0	714	10.00
11.00	01100	8,207	0	800	0	168	11.00
12.00	01200	0	0	0	0	0	12.00
13.00	01300	37,413	0	220	0	46	13.00
14.00	01400	3,648	0	0	0	0	14.00
15.00	01500	30,832	0	0	0	0	15.00
16.00	01600	10,173	0	2,263	0	475	16.00
17.00	01700	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	51,040	0	16,075	3,630	3,377	30.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	8,471	0	191	0	40	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	36,942	0	11,787	1,180	2,476	50.00
51.00	05100	0	0	0	0	0	51.00
52.00	05200	14,653	0	3,584	0	753	52.00
53.00	05300	2,683	0	0	0	0	53.00
54.00	05400	29,059	0	9,495	1,175	1,995	54.00
55.00	05500	0	0	0	0	0	55.00
56.00	05600	0	0	0	0	0	56.00
57.00	05700	2,378	0	0	0	0	57.00
58.00	05800	8,539	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	47,012	0	2,660	0	559	60.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	15,236	0	1,936	0	407	65.00
65.01	03950	1,539	0	104	0	22	65.01
66.00	06600	15,458	0	4,101	0	862	66.00
67.00	06700	2,323	0	967	0	203	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	5,732	0	0	0	0	69.00
70.00	07000	93	0	0	0	0	70.00
71.00	07100	7,746	0	2,568	0	539	71.00
72.00	07200	1,896	0	0	0	0	72.00
73.00	07300	6,857	0	1,117	0	235	73.00
74.00	07400	0	0	0	0	0	74.00
75.00	07500	0	0	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	67,859	0	6,483	4,051	1,362	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	0	0	0	0	0	116.00
118.00		475,790	0	69,639	10,036	14,233	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	40	0	195	0	41	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	6,280	0	23,691	0	4,976	192.00
193.00	19300	0	0	0	0	0	193.00
194.00	07950	5,829	0	101	0	21	194.00
194.01	07951	4,235	0	101	0	21	194.01
194.02	07952	2,520	0	0	0	0	194.02
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		494,694	0	93,727	10,036	19,292	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151301

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

Worksheet B
Part II
Date/Time Prepared:
11/25/2013 3:32 pm

Cost Center Description		DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
		10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	33,587					10.00
11.00	01100	0	14,999				11.00
12.00	01200	0	0	0			12.00
13.00	01300	0	1,944	0	41,223		13.00
14.00	01400	0	325	0	0	3,973	14.00
15.00	01500	0	359	0	0	0	15.00
16.00	01600	0	870	0	0	0	16.00
17.00	01700	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	33,587	3,037	0	20,652	0	30.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	379	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	846	0	5,752	0	50.00
51.00	05100	0	0	0	0	0	51.00
52.00	05200	0	625	0	0	0	52.00
53.00	05300	0	19	0	0	0	53.00
54.00	05400	0	1,364	0	0	0	54.00
55.00	05500	0	0	0	0	0	55.00
56.00	05600	0	0	0	0	0	56.00
57.00	05700	0	78	0	0	0	57.00
58.00	05800	0	97	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	0	380	0	0	0	60.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	0	820	0	0	0	65.00
65.01	03950	0	0	0	0	0	65.01
66.00	06600	0	816	0	0	0	66.00
67.00	06700	0	103	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	0	296	0	0	0	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	3,147	71.00
72.00	07200	0	0	0	0	826	72.00
73.00	07300	0	310	0	0	0	73.00
74.00	07400	0	0	0	0	0	74.00
75.00	07500	0	0	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	0	2,043	0	13,889	0	91.00
92.00	09200	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	0	0	0	0	0	116.00
118.00		33,587	14,711	0	40,293	3,973	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
192.00	19200	0	137	0	930	0	192.00
193.00	19300	0	0	0	0	0	193.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	111	0	0	0	194.01
194.02	07952	0	40	0	0	0	194.02
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		33,587	14,999	0	41,223	3,973	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151301

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

Worksheet B
Part II
Date/Time Prepared:
11/25/2013 3:32 pm

Cost Center Description		PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		15.00	16.00	17.00	24.00	25.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
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
12.00	01200						12.00
13.00	01300						13.00
14.00	01400						14.00
15.00	01500	73,196					15.00
16.00	01600		32,859				16.00
17.00	01700			0			17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000		2,259		320,158		30.00
42.00	04200						42.00
43.00	04300		306		10,776		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000		3,144		192,163		50.00
51.00	05100						51.00
52.00	05200		505		46,232		52.00
53.00	05300		253		2,955		53.00
54.00	05400		3,660		115,922		54.00
55.00	05500						55.00
56.00	05600						56.00
57.00	05700		5,300		7,756		57.00
58.00	05800		1,336		251,346		58.00
59.00	05900						59.00
60.00	06000		7,507		79,313		60.00
64.00	06400						64.00
65.00	06500		907		34,579		65.00
65.01	03950		190		2,891		65.01
66.00	06600		927		56,241		66.00
67.00	06700		161		10,804		67.00
68.00	06800						68.00
69.00	06900		446		6,474		69.00
70.00	07000		55		148		70.00
71.00	07100				32,708		71.00
72.00	07200				2,722		72.00
73.00	07300	73,196			89,852		73.00
74.00	07400						74.00
75.00	07500						75.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100		5,903		152,802		91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100						101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600						116.00
118.00		73,196	32,859		1,415,842		118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000				1,699		190.00
191.00	19100						191.00
192.00	19200				209,059		192.00
193.00	19300						193.00
194.00	07950				6,684		194.00
194.01	07951				5,201		194.01
194.02	07952				2,560		194.02
200.00							200.00
201.00							201.00
202.00		73,196	32,859		1,641,045		202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151301

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

Worksheet B
Part II
Date/Time Prepared:
11/25/2013 3:32 pm

Cost Center Description		Total	
		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
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	12.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	320,158
42.00	04200	SUBPROVIDER	0
43.00	04300	NURSERY	10,776
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	192,163
51.00	05100	RECOVERY ROOM	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	46,232
53.00	05300	ANESTHESIOLOGY	2,955
54.00	05400	RADIOLOGY-DIAGNOSTIC	115,922
55.00	05500	RADIOLOGY-THERAPEUTIC	0
56.00	05600	RADIOISOTOPE	0
57.00	05700	CT SCAN	7,756
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	251,346
59.00	05900	CARDIAC CATHETERIZATION	0
60.00	06000	LABORATORY	79,313
64.00	06400	INTRAVENOUS THERAPY	0
65.00	06500	RESPIRATORY THERAPY	34,579
65.01	03950	SLEEP LAB	2,891
66.00	06600	PHYSICAL THERAPY	56,241
67.00	06700	OCCUPATIONAL THERAPY	10,804
68.00	06800	SPEECH PATHOLOGY	0
69.00	06900	ELECTROCARDIOLOGY	6,474
70.00	07000	ELECTROENCEPHALOGRAPHY	148
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	32,708
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,722
73.00	07300	DRUGS CHARGED TO PATIENTS	89,852
74.00	07400	RENAL DIALYSIS	0
75.00	07500	ASC (NON-DISTINCT PART)	0
OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	152,802
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	
OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	0
SPECIAL PURPOSE COST CENTERS			
116.00	11600	HOSPICE	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,415,842
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,699
191.00	19100	RESEARCH	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	209,059
193.00	19300	NONPAID WORKERS	0
194.00	07950	OTHER NRCC - PUBLIC RELATIONS	6,684
194.01	07951	OTHER NRCC - FOUNDATION	5,201
194.02	07952	OTHER NRCC - GRANTS	2,560
200.00		Cross Foot Adjustments	0
201.00		Negative Cost Centers	0
202.00		TOTAL (sum lines 118-201)	1,641,045

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151301

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

Worksheet B-1

Date/Time Prepared:
11/25/2013 3:32 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQ. FEET)	MVBLE EQUIP (SQ. FEET)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	78,457				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		78,457			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	8,512,868		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	12,342	12,342	1,915,422	-5,993,606	17,733,212 5.00
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00 00700	OPERATION OF PLANT	4,688	4,688	260,979	0	1,491,806 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	640	640	0	0	69,724 8.00
9.00 00900	HOUSEKEEPING	600	600	0	0	419,712 9.00
10.00 01000	DIETARY	2,226	2,226	2,577	0	169,666 10.00
11.00 01100	CAFETERIA	524	524	6,785	0	294,206 11.00
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0 12.00
13.00 01300	NURSING ADMINISTRATION	144	144	919,224	0	1,341,170 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	91,358	0	130,778 14.00
15.00 01500	PHARMACY	0	0	264,876	0	1,105,258 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	1,483	1,483	207,534	0	364,677 16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	0 17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	10,535	10,535	1,122,346	0	1,829,647 30.00
42.00 04200	SUBPROVIDER	0	0	0	0	0 42.00
43.00 04300	NURSERY	125	125	184,706	0	303,678 43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	7,725	7,725	399,831	0	1,324,277 50.00
51.00 05100	RECOVERY ROOM	0	0	0	0	0 51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	2,349	2,349	305,007	0	525,284 52.00
53.00 05300	ANESTHESIOLOGY	0	0	55,329	0	96,175 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	6,223	6,223	613,912	0	1,041,700 54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0 55.00
56.00 05600	RADIOISOTOPE	0	0	0	0	0 56.00
57.00 05700	CT SCAN	0	0	31,917	0	85,246 57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	46,436	0	306,094 58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0 59.00
60.00 06000	LABORATORY	1,743	1,743	116,949	0	1,685,247 60.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0 64.00
65.00 06500	RESPIRATORY THERAPY	1,269	1,269	369,338	0	546,179 65.00
65.01 03950	SLEEP LAB	68	68	0	0	55,175 65.01
66.00 06600	PHYSICAL THERAPY	2,688	2,688	350,454	0	554,137 66.00
67.00 06700	OCCUPATIONAL THERAPY	634	634	55,228	0	83,291 67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	0 68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	134,544	0	205,464 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	3,320 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,683	1,683	0	0	277,689 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	67,967 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	732	732	155,652	0	245,791 73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	0 74.00
75.00 07500	ASC (NON-DISTINCT PART)	0	0	0	0	0 75.00
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	4,249	4,249	802,891	0	2,432,201 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS						
101.00 10100	HOME HEALTH AGENCY	0	0	0	0	0 101.00
SPECIAL PURPOSE COST CENTERS						
116.00 11600	HOSPICE	0	0	0	0	0 116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	62,670	62,670	8,413,295	-5,993,606	17,055,559 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	128	128	0	0	1,423 190.00
191.00 19100	RESEARCH	0	0	0	0	0 191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	15,527	15,527	35,446	0	225,124 192.00
193.00 19300	NONPAID WORKERS	0	0	0	0	0 193.00
194.00 07950	OTHER NRCC - PUBLIC RELATIONS	66	66	0	0	208,956 194.00
194.01 07951	OTHER NRCC - FOUNDATION	66	66	46,472	0	151,826 194.01
194.02 07952	OTHER NRCC - GRANTS	0	0	17,655	0	90,324 194.02
200.00	Cross Foot Adjustments					
201.00	Negative Cost Centers					
202.00	Cost to be allocated (per wkst. B, Part I)	587,567	284,553	3,235,641		5,993,606 202.00
203.00	Unit cost multiplier (wkst. B, Part I)	7.489032	3.626866	0.380088		0.337988 203.00
204.00	Cost to be allocated (per wkst. B, Part II)			0		494,694 204.00

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COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151301

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

Worksheet B-1
Date/Time Prepared:
11/25/2013 3:32 pm

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				
205.00	Unit cost multiplier (wkst. B, Part II)		0.000000		0.027896	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151301

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

Worksheet B-I

Date/Time Prepared:
11/25/2013 3:32 pm

Cost Center Description		MAINTENANCE & REPAIRS (ASSIGNED TIME)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL						5.00
6.00	00600 MAINTENANCE & REPAIRS	0					6.00
7.00	00700 OPERATION OF PLANT	0	61,427				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	640	79,299			8.00
9.00	00900 HOUSEKEEPING	0	600	0	60,187		9.00
10.00	01000 DIETARY	0	2,226	0	2,226	100	10.00
11.00	01100 CAFETERIA	0	524	0	524	0	11.00
12.00	01200 MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300 NURSING ADMINISTRATION	0	144	0	144	0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500 PHARMACY	0	0	0	0	0	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	1,483	0	1,483	0	16.00
17.00	01700 SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	0	10,535	28,681	10,535	100	30.00
42.00	04200 SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300 NURSERY	0	125	0	125	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	7,725	9,322	7,725	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	2,349	0	2,349	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	6,223	9,281	6,223	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600 RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	1,743	0	1,743	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	1,269	0	1,269	0	65.00
65.01	03950 SLEEP LAB	0	68	0	68	0	65.01
66.00	06600 PHYSICAL THERAPY	0	2,688	0	2,688	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	634	0	634	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,683	0	1,683	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	732	0	732	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	0	4,249	32,015	4,249	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600 HOSPICE	0	0	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	45,640	79,299	44,400	100	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	128	0	128	0	190.00
191.00	19100 RESEARCH	0	0	0	0	0	191.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	15,527	0	15,527	0	192.00
193.00	19300 NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950 OTHER NRCC - PUBLIC RELATIONS	0	66	0	66	0	194.00
194.01	07951 OTHER NRCC - FOUNDATION	0	66	0	66	0	194.01
194.02	07952 OTHER NRCC - GRANTS	0	0	0	0	0	194.02
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per wkst. B, Part I)	0	1,996,019	114,086	581,066	320,834	202.00
203.00	Unit cost multiplier (wkst. B, Part I)	0.000000	32.494164	1.438681	9.654344	3,208.340000	203.00
204.00	Cost to be allocated (per wkst. B, Part II)	0	93,727	10,036	19,292	33,587	204.00
205.00	Unit cost multiplier (wkst. B, Part II)	0.000000	1.525827	0.126559	0.320534	335.870000	205.00

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COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151301

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

Worksheet B-1

Date/Time Prepared:
11/25/2013 3:32 pm

Cost Center Description			CAFETERIA (HOURS)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			11.00	12.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	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
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	231,595					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	30,016	0	93,619			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,015	0	0	326,948		14.00
15.00	01500	PHARMACY	5,545	0	0	0	10,000	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	13,434	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	46,902	0	46,902	0	0	30.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	5,845	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	13,062	0	13,062	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,651	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	286	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	21,067	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	1,212	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,500	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	5,865	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	12,664	0	0	0	0	65.00
65.01	03950	SLEEP LAB	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	12,594	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,597	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,567	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	258,981	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	67,967	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,794	0	0	0	10,000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	31,543	0	31,543	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	227,159	0	91,507	326,948	10,000	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,112	0	2,112	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NRCC - PUBLIC RELATIONS	0	0	0	0	0	194.00
194.01	07951	OTHER NRCC - FOUNDATION	1,708	0	0	0	0	194.01
194.02	07952	OTHER NRCC - GRANTS	616	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per wkst. B, Part I)	415,730	0	1,854,419	183,981	1,488,776	202.00
203.00		Unit cost multiplier (wkst. B, Part I)	1.795073	0.000000	19.808148	0.562723	148.877600	203.00
204.00		Cost to be allocated (per wkst. B, Part II)	14,999	0	41,223	3,973	73,196	204.00
205.00		Unit cost multiplier (wkst. B, Part II)	0.064764	0.000000	0.440327	0.012152	7.319600	205.00

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COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151301

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

Worksheet B-1

Date/Time Prepared:
11/25/2013 3:32 pm

Cost Center Description		MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	
		16.00	17.00	
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
6.00	00600	MAINTENANCE & REPAIRS		6.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
12.00	01200	MAINTENANCE OF PERSONNEL		12.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	63,327,113	16.00
17.00	01700	SOCIAL SERVICE	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	4,353,461	30.00
42.00	04200	SUBPROVIDER	0	42.00
43.00	04300	NURSERY	589,049	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	6,057,940	50.00
51.00	05100	RECOVERY ROOM	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	972,700	52.00
53.00	05300	ANESTHESIOLOGY	488,390	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,051,181	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	55.00
56.00	05600	RADIOISOTOPE	0	56.00
57.00	05700	CT SCAN	10,211,637	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,573,618	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	59.00
60.00	06000	LABORATORY	14,482,416	60.00
64.00	06400	INTRAVENOUS THERAPY	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,746,928	65.00
65.01	03950	SLEEP LAB	365,528	65.01
66.00	06600	PHYSICAL THERAPY	1,785,828	66.00
67.00	06700	OCCUPATIONAL THERAPY	310,166	67.00
68.00	06800	SPEECH PATHOLOGY	0	68.00
69.00	06900	ELECTROCARDIOLOGY	859,150	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	106,025	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
74.00	07400	RENAL DIALYSIS	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	75.00
OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	11,373,096	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	92.00
OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	101.00
SPECIAL PURPOSE COST CENTERS				
116.00	11600	HOSPICE	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	63,327,113	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
191.00	19100	RESEARCH	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
193.00	19300	NONPAID WORKERS	0	193.00
194.00	07950	OTHER NRCC - PUBLIC RELATIONS	0	194.00
194.01	07951	OTHER NRCC - FOUNDATION	0	194.01
194.02	07952	OTHER NRCC - GRANTS	0	194.02
200.00		Cross Foot Adjustments		200.00
201.00		Negative Cost Centers		201.00
202.00		Cost to be allocated (per wkst. B, Part I)	574,554	202.00
203.00		Unit cost multiplier (wkst. B, Part I)	0.009073	203.00
204.00		Cost to be allocated (per wkst. B, Part II)	32,859	204.00
205.00		Unit cost multiplier (wkst. B, Part II)	0.000519	205.00

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COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151301

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

Worksheet C
Part I
Date/Time Prepared:
11/25/2013 3:32 pm

		Title XVIII		Hospital		Cost
Cost Center Description		Total Cost (From Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Disallowance	Total Costs
		1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	4,306,911		4,306,911	0	0 30.00
42.00	04200 SUBPROVIDER	0		0	0	0 42.00
43.00	04300 NURSERY	427,423		427,423	0	0 43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	2,448,020		2,448,020	0	0 50.00
51.00	05100 RECOVERY ROOM	0		0	0	0 51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	827,980		827,980	0	0 52.00
53.00	05300 ANESTHESIOLOGY	133,625		133,625	0	0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,771,216		1,771,216	0	0 54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0		0	0	0 55.00
56.00	05600 RADIOISOTOPE	0		0	0	0 56.00
57.00	05700 CT SCAN	208,884		208,884	0	0 57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	435,593		435,593	0	0 58.00
59.00	05900 CARDIAC CATHETERIZATION	0		0	0	0 59.00
60.00	06000 LABORATORY	2,470,221		2,470,221	0	0 60.00
64.00	06400 INTRAVENOUS THERAPY	0		0	0	0 64.00
65.00	06500 RESPIRATORY THERAPY	822,850	0	822,850	0	0 65.00
65.01	03950 SLEEP LAB	80,005	0	80,005	0	0 65.01
66.00	06600 PHYSICAL THERAPY	893,534	0	893,534	0	0 66.00
67.00	06700 OCCUPATIONAL THERAPY	143,845	0	143,845	0	0 67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0 68.00
69.00	06900 ELECTROCARDIOLOGY	290,901		290,901	0	0 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	5,404		5,404	0	0 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	588,215		588,215	0	0 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	129,186		129,186	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,857,100		1,857,100	0	0 73.00
74.00	07400 RENAL DIALYSIS	0		0	0	0 74.00
75.00	07500 ASC (NON-DISTINCT PART)	0		0	0	0 75.00
OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	4,264,017		4,264,017	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	810,939		810,939	0	0 92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	0		0		0 101.00
SPECIAL PURPOSE COST CENTERS						
116.00	11600 HOSPICE	0		0		0 116.00
200.00	Subtotal (see instructions)	22,915,869	0	22,915,869	0	0 200.00
201.00	Less Observation Beds	810,939		810,939		0 201.00
202.00	Total (see instructions)	22,104,930	0	22,104,930	0	0 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151301

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

Worksheet C
Part I
Date/Time Prepared:
11/25/2013 3:32 pm

			Title XVIII			Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,080,497		3,080,497			30.00
42.00	04200	SUBPROVIDER	0		0			42.00
43.00	04300	NURSERY	589,049		589,049			43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,527,181	4,530,759	6,057,940	0.404101	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	972,700	0	972,700	0.851218	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	90,703	397,687	488,390	0.273603	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	404,129	6,736,767	7,140,896	0.248038	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0.000000	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
57.00	05700	CT SCAN	584,689	9,626,949	10,211,638	0.020455	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	99,818	2,473,799	2,573,617	0.169253	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	1,390,385	13,092,031	14,482,416	0.170567	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	1,053,507	693,423	1,746,930	0.471026	0.000000	65.00
65.01	03950	SLEEP LAB	757	364,771	365,528	0.218875	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	128,082	1,657,746	1,785,828	0.500347	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	62,756	247,410	310,166	0.463768	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	170,170	688,980	859,150	0.338592	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	798	15,512	16,310	0.331330	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	999,220	1,225,725	2,224,945	0.264373	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	389,876	234,766	624,642	0.206816	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,942,968	3,972,283	5,915,251	0.313951	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	75.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	356,342	11,017,350	11,373,692	0.374902	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	33,799	1,239,165	1,272,964	0.637048	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	13,877,426	58,215,123	72,092,549			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	13,877,426	58,215,123	72,092,549			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151301

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

Worksheet C
Part I
Date/Time Prepared:
11/25/2013 3:32 pm

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
42.00	04200	SUBPROVIDER			42.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY--DIAGNOSTIC	0.000000		54.00
55.00	05500	RADIOLOGY--THERAPEUTIC	0.000000		55.00
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRT)	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.000000		60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
65.01	03950	SLEEP LAB	0.000000		65.01
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
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
74.00	07400	RENAL DIALYSIS	0.000000		74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000		75.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS					
116.00	11600	HOSPICE			116.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 151301	Period: From 07/01/2012 To 06/30/2013	Worksheet C Part I Date/Time Prepared: 11/25/2013 3:32 pm
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Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Hospital		Total Costs	
			Costs			
			Total Costs	RCE Disallowance		
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS		4,306,911	0	0	30.00
42.00	04200 SUBPROVIDER		0	0	0	42.00
43.00	04300 NURSERY		427,423	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM		2,448,020	0	0	50.00
51.00	05100 RECOVERY ROOM		0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		827,980	0	0	52.00
53.00	05300 ANESTHESIOLOGY		133,625	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		1,771,216	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC		0	0	0	55.00
56.00	05600 RADIOISOTOPE		0	0	0	56.00
57.00	05700 CT SCAN		208,884	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		435,593	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION		0	0	0	59.00
60.00	06000 LABORATORY		2,470,221	0	0	60.00
64.00	06400 INTRAVENOUS THERAPY		0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	822,850	0	0	65.00
65.01	03950 SLEEP LAB	0	80,005	0	0	65.01
66.00	06600 PHYSICAL THERAPY	0	893,534	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	143,845	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY		290,901	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY		5,404	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		588,215	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		129,186	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		1,857,100	0	0	73.00
74.00	07400 RENAL DIALYSIS		0	0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)		0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY		4,264,017	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		810,939	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY		0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
116.00	11600 HOSPICE		0	0	0	116.00
200.00	Subtotal (see instructions)		22,915,869	0	0	200.00
201.00	Less Observation Beds		810,939	0	0	201.00
202.00	Total (see instructions)		22,104,930	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151301

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

Worksheet C
Part I
Date/Time Prepared:
11/25/2013 3:32 pm

			Title XIX			Hospital	Cost
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				
	9.00	10.00					
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,080,497		3,080,497		30.00
42.00	04200	SUBPROVIDER	0		0		42.00
43.00	04300	NURSERY	589,049		589,049		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,527,181	4,530,759	6,057,940	0.404101	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	972,700	0	972,700	0.851218	52.00
53.00	05300	ANESTHESIOLOGY	90,703	397,687	488,390	0.273603	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	404,129	6,736,767	7,140,896	0.248038	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	584,689	9,626,949	10,211,638	0.020455	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	99,818	2,473,799	2,573,617	0.169253	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	1,390,385	13,092,031	14,482,416	0.170567	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	1,053,507	693,423	1,746,930	0.471026	65.00
65.01	03950	SLEEP LAB	757	364,771	365,528	0.218875	65.01
66.00	06600	PHYSICAL THERAPY	128,082	1,657,746	1,785,828	0.500347	66.00
67.00	06700	OCCUPATIONAL THERAPY	62,756	247,410	310,166	0.463768	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	170,170	688,980	859,150	0.338592	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	798	15,512	16,310	0.331330	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	999,220	1,225,725	2,224,945	0.264373	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	389,876	234,766	624,642	0.206816	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,942,968	3,972,283	5,915,251	0.313951	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	75.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	356,342	11,017,350	11,373,692	0.374902	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	33,799	1,239,165	1,272,964	0.637048	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	HOSPICE	0	0	0		116.00
200.00		Subtotal (see instructions)	13,877,426	58,215,123	72,092,549		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	13,877,426	58,215,123	72,092,549		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151301

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

Worksheet C
Part I
Date/Time Prepared:
11/25/2013 3:32 pm

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
42.00	04200	SUBPROVIDER			42.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000		55.00
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.000000		60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
65.01	03950	SLEEP LAB	0.000000		65.01
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
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
74.00	07400	RENAL DIALYSIS	0.000000		74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000		75.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS					
116.00	11600	HOSPICE			116.00
200.00		Subtotal (see instructions)			200.00
201.00		Less observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: I51301

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

Worksheet D
Part II
Date/Time Prepared:
11/25/2013 3:32 pm

Cost Center Description		Title XVIII			Hospital	Cost		
		Capital Related Cost (from wkst. B, Part II, col. 26)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	192,163	6,057,940	0.031721	213,393	6,769	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	46,232	972,700	0.047530	2,580	123	52.00
53.00	05300	ANESTHESIOLOGY	2,955	488,390	0.006050	9,575	58	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	115,922	7,140,896	0.016234	88,480	1,436	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0.000000	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	7,756	10,211,638	0.000760	184,474	140	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	251,346	2,573,617	0.097663	55,089	5,380	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	79,313	14,482,416	0.005477	534,943	2,930	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	34,579	1,746,930	0.019794	621,250	12,297	65.00
65.01	03950	SLEEP LAB	2,891	365,528	0.007909	757	6	65.01
66.00	06600	PHYSICAL THERAPY	56,241	1,785,828	0.031493	57,112	1,799	66.00
67.00	06700	OCCUPATIONAL THERAPY	10,804	310,166	0.034833	30,725	1,070	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	6,474	859,150	0.007535	165,212	1,245	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	148	16,310	0.009074	41	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	32,708	2,224,945	0.014701	390,436	5,740	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,722	624,642	0.004358	91,107	397	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	89,852	5,915,251	0.015190	873,786	13,273	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	152,802	11,373,692	0.013435	12,281	165	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,272,964	0.000000	25,024	0	92.00
200.00		Total (lines 50-199)	1,084,908	68,423,003		3,356,265	52,828	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151301

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

Worksheet D
Part IV
Date/Time Prepared:
11/25/2013 3:32 pm

Cost Center Description		Title XVIII				Hospital	Cost	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
65.01	03950	SLEEP LAB	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
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
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
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: 151301

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

Worksheet D
Part IV
Date/Time Prepared:
11/25/2013 3:32 pm

			Title XVIII			Hospital		Cost		
Cost Center Description			Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges			
			6.00	7.00	8.00	9.00	10.00			
ANCILLARY SERVICE COST CENTERS										
50.00	05000	OPERATING ROOM	0	6,057,940	0.000000	0.000000	213,393	50.00		
51.00	05100	RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00		
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	972,700	0.000000	0.000000	2,580	52.00		
53.00	05300	ANESTHESIOLOGY	0	488,390	0.000000	0.000000	9,575	53.00		
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	7,140,896	0.000000	0.000000	88,480	54.00		
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0.000000	0.000000	0	55.00		
56.00	05600	RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00		
57.00	05700	CT SCAN	0	10,211,638	0.000000	0.000000	184,474	57.00		
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	2,573,617	0.000000	0.000000	55,089	58.00		
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00		
60.00	06000	LABORATORY	0	14,482,416	0.000000	0.000000	534,943	60.00		
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0	64.00		
65.00	06500	RESPIRATORY THERAPY	0	1,746,930	0.000000	0.000000	621,250	65.00		
65.01	03950	SLEEP LAB	0	365,528	0.000000	0.000000	757	65.01		
66.00	06600	PHYSICAL THERAPY	0	1,785,828	0.000000	0.000000	57,112	66.00		
67.00	06700	OCCUPATIONAL THERAPY	0	310,166	0.000000	0.000000	30,725	67.00		
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00		
69.00	06900	ELECTROCARDIOLOGY	0	859,150	0.000000	0.000000	165,212	69.00		
70.00	07000	ELECTROENCEPHALOGRAPHY	0	16,310	0.000000	0.000000	41	70.00		
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,224,945	0.000000	0.000000	390,436	71.00		
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	624,642	0.000000	0.000000	91,107	72.00		
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,915,251	0.000000	0.000000	873,786	73.00		
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0.000000	0	74.00		
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0.000000	0	75.00		
OUTPATIENT SERVICE COST CENTERS										
91.00	09100	EMERGENCY	0	11,373,692	0.000000	0.000000	12,281	91.00		
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,272,964	0.000000	0.000000	25,024	92.00		
200.00		Total (lines 50-199)	0	68,423,003			3,356,265	200.00		

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151301

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

Worksheet D
Part IV
Date/Time Prepared:
11/25/2013 3:32 pm

Cost Center Description		Title XVIII			Hospital		Cost
		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
65.01	03950	SLEEP LAB	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
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
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
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: 151301	Period: From 07/01/2012 To 06/30/2013	Worksheet D Part IV Date/Time Prepared: 11/25/2013 3:32 pm
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Cost Center Description		PSA Adj. Allied Health	PSA Adj. All other Medical Education Cost	Hospital	Cost
		23.00	24.00		
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	0		50.00
51.00	05100 RECOVERY ROOM	0	0		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300 ANESTHESIOLOGY	0	0		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0		55.00
56.00	05600 RADIOISOTOPE	0	0		56.00
57.00	05700 CT SCAN	0	0		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000 LABORATORY	0	0		60.00
64.00	06400 INTRAVENOUS THERAPY	0	0		64.00
65.00	06500 RESPIRATORY THERAPY	0	0		65.00
65.01	03950 SLEEP LAB	0	0		65.01
66.00	06600 PHYSICAL THERAPY	0	0		66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800 SPEECH PATHOLOGY	0	0		68.00
69.00	06900 ELECTROCARDIOLOGY	0	0		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
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
74.00	07400 RENAL DIALYSIS	0	0		74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0		75.00
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: 151301	Period: From 07/01/2012 To 06/30/2013	Worksheet D Part V Date/Time Prepared: 11/25/2013 3:32 pm
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		Title XVIII		Hospital		Cost		
Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	PPS Reimbursed Services (see inst.)	Charges		Costs		PPS Services (see inst.)	
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services (see inst.)	Costs (see inst.)		
	1.00	2.00	3.00	4.00	5.00			
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.404101	0	1,275,638	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.851218	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.273603	0	119,960	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.248038	0	1,431,580	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.020455	0	2,796,250	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.169253	0	655,096	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.170567	0	3,435,129	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.471026	0	260,005	0	0	65.00
65.01	03950	SLEEP LAB	0.218875	0	99,764	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.500347	0	490,500	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.463768	0	35,162	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.338592	0	578,552	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.331330	0	5,463	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.264373	0	561,416	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.206816	0	97,617	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.313951	0	1,468,276	3,643	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0.374902	0	3,086,920	4,720	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.637048	0	270,571	0	0	92.00
200.00		Subtotal (see instructions)		0	16,667,899	8,363	0	200.00
201.00		Less PBP Clinic Lab. Services-Program only Charges		0	0	0	0	201.00
202.00		Net Charges (line 200 +/- line 201)		0	16,667,899	8,363	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151301	Period: From 07/01/2012 To 06/30/2013	Worksheet D Part V Date/Time Prepared: 11/25/2013 3:32 pm
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Cost Center Description	Costs		Hospital	Cost	
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
	6.00	7.00			
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	515,487	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	32,821	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	355,086	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	57,197	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	110,877	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	585,920	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	122,469	0	65.00
65.01	03950	SLEEP LAB	21,836	0	65.01
66.00	06600	PHYSICAL THERAPY	245,420	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	16,307	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	195,893	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,810	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	148,423	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	20,189	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	460,967	1,144	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	75.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	1,157,292	1,770	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	172,367	0	92.00
200.00		Subtotal (see instructions)	4,220,361	2,914	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (Line 200 +/- line 201)	4,220,361	2,914	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151301 Component CCN: 152301	Period: From 07/01/2012 To 06/30/2013	Worksheet D Part V Date/Time Prepared: 11/25/2013 3:32 pm
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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	0.404101	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.851218	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.273603	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.248038	0	0	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
56.00	05600 RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700 CT SCAN	0.020455	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.169253	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000 LABORATORY	0.170567	0	0	0	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.471026	0	0	0	0	65.00
65.01	03950 SLEEP LAB	0.218875	0	0	0	0	65.01
66.00	06600 PHYSICAL THERAPY	0.500347	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.463768	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.338592	0	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.331330	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.264373	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.206816	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.313951	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0.000000	0	0	0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	0.374902	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.637048	0	0	0	0	92.00
200.00	Subtotal (see instructions)		0	0	0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151301

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

Worksheet D
Part V
Date/Time Prepared:
11/25/2013 3:32 pm

Component CCN: 152301

Cost Center Description		Costs		Swing Beds - SNF	Cost
		Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
		6.00	7.00		
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
65.01	03950	SLEEP LAB	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
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
74.00	07400	RENAL DIALYSIS	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	75.00
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

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 151301	Period: From 07/01/2012 To 06/30/2013	Worksheet D Part I Date/Time Prepared: 11/25/2013 3:32 pm
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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	320,158	16,660	303,498	2,905	104.47	30.00
42.00	SUBPROVIDER	0	0	0	0	0.00	42.00
43.00	NURSERY	10,776		10,776	427	25.24	43.00
200.00	Total (lines 30-199)	330,934		314,274	3,332		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	88	9,193				30.00
42.00	SUBPROVIDER	0	0				42.00
43.00	NURSERY	270	6,815				43.00
200.00	Total (lines 30-199)	358	16,008				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 151301	Period: From 07/01/2012 To 06/30/2013	Worksheet D Part II Date/Time Prepared: 11/25/2013 3:32 pm
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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)	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	192,163	6,057,940	0.031721	430,873	13,668	50.00
51.00	05100 RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	46,232	972,700	0.047530	0	0	52.00
53.00	05300 ANESTHESIOLOGY	2,955	488,390	0.006050	22,733	138	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	115,922	7,140,896	0.016234	39,546	642	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0.000000	0	0	55.00
56.00	05600 RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700 CT SCAN	7,756	10,211,638	0.000760	44,652	34	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	251,346	2,573,617	0.097663	16,030	1,566	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000 LABORATORY	79,313	14,482,416	0.005477	292,176	1,600	60.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	34,579	1,746,930	0.019794	148,155	2,933	65.00
65.01	03950 SLEEP LAB	2,891	365,528	0.007909	0	0	65.01
66.00	06600 PHYSICAL THERAPY	56,241	1,785,828	0.031493	5,889	185	66.00
67.00	06700 OCCUPATIONAL THERAPY	10,804	310,166	0.034833	1,573	55	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	6,474	859,150	0.007535	4,468	34	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	148	16,310	0.009074	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	32,708	2,224,945	0.014701	84,585	1,243	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	2,722	624,642	0.004358	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	89,852	5,915,251	0.015190	334,800	5,086	73.00
74.00	07400 RENAL DIALYSIS	0	0	0.000000	0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	152,802	11,373,692	0.013435	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1,272,964	0.000000	0	0	92.00
200.00	Total (lines 50-199)	1,084,908	68,423,003		1,425,480	27,184	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151301	Period: From 07/01/2012 To 06/30/2013	Worksheet D Part III Date/Time Prepared: 11/25/2013 3:32 pm
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Cost Center Description			Title XIX			Hospital		Cost
			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. Nursing School	
			6.00	7.00	8.00	9.00	11.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,905	0.00	88	0	0	30.00
42.00	04200	SUBPROVIDER	0	0.00	0	0	0	42.00
43.00	04300	NURSERY	427	0.00	270	0	0	43.00
200.00		Total (lines 30-199)	3,332		358	0	0	200.00
Cost Center Description			PSA Adj. Allied Health Cost	PSA Adj. All Other Medical Education Cost				
			12.00	13.00				
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0				30.00
42.00	04200	SUBPROVIDER	0	0				42.00
43.00	04300	NURSERY	0	0				43.00
200.00		Total (lines 30-199)	0	0				200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151301	Period: From 07/01/2012 To 06/30/2013	Worksheet D Part IV Date/Time Prepared: 11/25/2013 3:32 pm
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Cost Center Description	Title XIX				Hospital	Cost	
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)		
	1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
65.01	03950	SLEEP LAB	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
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
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
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: 151301

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

Worksheet D
Part IV
Date/Time Prepared:
11/25/2013 3:32 pm

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	6,057,940	0.000000	0.000000	430,873	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	972,700	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	488,390	0.000000	0.000000	22,733	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	7,140,896	0.000000	0.000000	39,546	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0.000000	0.000000	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
57.00	05700	CT SCAN	0	10,211,638	0.000000	0.000000	44,652	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	2,573,617	0.000000	0.000000	16,030	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	14,482,416	0.000000	0.000000	292,176	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,746,930	0.000000	0.000000	148,155	65.00
65.01	03950	SLEEP LAB	0	365,528	0.000000	0.000000	0	65.01
66.00	06600	PHYSICAL THERAPY	0	1,785,828	0.000000	0.000000	5,889	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	310,166	0.000000	0.000000	1,573	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	859,150	0.000000	0.000000	4,468	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	16,310	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,224,945	0.000000	0.000000	84,585	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	624,642	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,915,251	0.000000	0.000000	334,800	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0.000000	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0.000000	0	75.00
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	11,373,692	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,272,964	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	68,423,003			1,425,480	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151301

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

Worksheet D
Part IV
Date/Time Prepared:
11/25/2013 3:32 pm

Cost Center Description		Title XIX			Hospital		Cost
		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
65.01	03950	SLEEP LAB	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
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
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
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: 151301

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

Worksheet 0
Part IV
Date/Time Prepared:
11/25/2013 3:32 pm

Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	Title XIX	Hospital	Cost
		23.00	24.00			
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0			50.00
51.00	05100 RECOVERY ROOM	0	0			51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0			52.00
53.00	05300 ANESTHESIOLOGY	0	0			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0			54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0			55.00
56.00	05600 RADIOISOTOPE	0	0			56.00
57.00	05700 CT SCAN	0	0			57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0			58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0			59.00
60.00	06000 LABORATORY	0	0			60.00
64.00	06400 INTRAVENOUS THERAPY	0	0			64.00
65.00	06500 RESPIRATORY THERAPY	0	0			65.00
65.01	03950 SLEEP LAB	0	0			65.01
66.00	06600 PHYSICAL THERAPY	0	0			66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0			67.00
68.00	06800 SPEECH PATHOLOGY	0	0			68.00
69.00	06900 ELECTROCARDIOLOGY	0	0			69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0			70.00
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
74.00	07400 RENAL DIALYSIS	0	0			74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0			75.00
OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	0	0			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0			92.00
200.00	Total (lines 50-199)	0	0			200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151301	Period: From 07/01/2012 To 06/30/2013	Worksheet D-1 Date/Time Prepared: 11/25/2013 3:32 pm
Cost Center Description		Title XVIII	Hospital	Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			3,140 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			2,905 2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.			0 3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			2,328 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			76 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)			76 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			42 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)			41 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			1,186 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)			76 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)			76 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0 14.00
15.00	Total nursery days (title V or XIX only)			0 15.00
16.00	Nursery days (title V or XIX only)			0 16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			126.36 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			126.36 20.00
21.00	Total general inpatient routine service cost (see instructions)			4,306,911 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)			5,307 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)			5,181 25.00
26.00	Total swing-bed cost (see instructions)			224,115 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			4,082,796 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)			4,082,796 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)			1,405.44 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			1,666,852 39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			0 40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			1,666,852 41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151301		Period: From 07/01/2012 To 06/30/2013		Worksheet D-1 Date/Time Prepared: 11/25/2013 3:32 pm	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Hospital Program Days	Cost Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	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							
48.00	Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					1,025,838	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,692,690	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)					106,813	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					106,813	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					213,626	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)					577	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,405.44	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					810,939	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151301		Period: From 07/01/2012 To 06/30/2013		Worksheet D-1 Date/Time Prepared: 11/25/2013 3:32 pm	
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Hospital		Cost	
	1.00	2.00	3.00	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151301	Period: From 07/01/2012 To 06/30/2013	Worksheet D-1 Date/Time Prepared: 11/25/2013 3:32 pm
Cost Center Description		Title XIX	Hospital	Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			3,140 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			2,905 2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.			0 3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			2,328 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			76 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)			76 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			42 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)			41 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			88 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)			427 15.00
16.00	Nursery days (title V or XIX only)			270 16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			126.36 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			126.36 20.00
21.00	Total general inpatient routine service cost (see instructions)			4,306,911 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)			5,307 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)			5,181 25.00
26.00	Total swing-bed cost (see instructions)			224,115 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			4,082,796 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)			4,082,796 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)			1,405.44 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			123,679 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)			123,679 41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151301		Period: From 07/01/2012 To 06/30/2013		Worksheet D-1 Date/Time Prepared: 11/25/2013 3:32 pm	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Hospital Program Days	Program Cost (col. 3 x col. 4)	
42.00	NURSERY (title V & XIX only)	427,423	427	1,000.99	270	270,267	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)					446,055	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					840,001	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)					577	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,405.44	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					810,939	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151301

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

Worksheet D-1

Date/Time Prepared:
11/25/2013 3:32 pm

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151301	Period: From 07/01/2012 To 06/30/2013	Worksheet D-3	
Cost Center Description		Ratio of Cost To Charges	Hospital Inpatient Program Charges	Cost Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		1,221,886	30.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.404101	213,393	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.851218	2,580	52.00
53.00	05300	ANESTHESIOLOGY	0.273603	9,575	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.248038	88,480	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	0	56.00
57.00	05700	CT SCAN	0.020455	184,474	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.169253	55,089	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.170567	534,943	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.471026	621,250	65.00
65.01	03950	SLEEP LAB	0.218875	757	65.01
66.00	06600	PHYSICAL THERAPY	0.500347	57,112	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.463768	30,725	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.338592	165,212	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.331330	41	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.264373	390,436	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.206816	91,107	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.313951	873,786	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	75.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.374902	12,281	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.637048	25,024	92.00
200.00		Total (sum of lines 50-94 and 96-98)		3,356,265	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net Charges (line 200 minus line 201)		3,356,265	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 151301 Component CCN: 152301	Period: From 07/01/2012 To 06/30/2013	Worksheet D-3 Date/Time Prepared: 11/25/2013 3:32 pm
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Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	Cost
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
42.00	04200 SUBPROVIDER		0		42.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.404101	4,070	1,645	50.00
51.00	05100 RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.851218	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.273603	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.248038	3,672	911	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	55.00
56.00	05600 RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700 CT SCAN	0.020455	1,886	39	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.169253	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000 LABORATORY	0.170567	1,070	183	60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.471026	47,808	22,519	65.00
65.01	03950 SLEEP LAB	0.218875	0	0	65.01
66.00	06600 PHYSICAL THERAPY	0.500347	28,587	14,303	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.463768	13,739	6,372	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.338592	490	166	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.331330	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.264373	30,590	8,087	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.206816	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.313951	92,682	29,098	73.00
74.00	07400 RENAL DIALYSIS	0.000000	0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY	0.374902	237	89	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.637048	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		224,831	83,412	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)		224,831		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151301	Period: From 07/01/2012 To 06/30/2013	Worksheet D-3 Date/Time Prepared: 11/25/2013 3:32 pm
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Cost Center Description		Title XIX	Hospital	Cost
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		
42.00	04200	SUBPROVIDER	1,434,391	30.00
43.00	04300	NURSERY	0	42.00
			0	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.404101	430,873
51.00	05100	RECOVERY ROOM	0.000000	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.851218	0
53.00	05300	ANESTHESIOLOGY	0.273603	22,733
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.248038	39,546
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0
56.00	05600	RADIOISOTOPE	0.000000	0
57.00	05700	CT SCAN	0.020455	44,652
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.169253	16,030
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0
60.00	06000	LABORATORY	0.170567	292,176
64.00	06400	INTRAVENOUS THERAPY	0.000000	0
65.00	06500	RESPIRATORY THERAPY	0.471026	148,155
65.01	03950	SLEEP LAB	0.218875	0
66.00	06600	PHYSICAL THERAPY	0.500347	5,889
67.00	06700	OCCUPATIONAL THERAPY	0.463768	1,573
68.00	06800	SPEECH PATHOLOGY	0.000000	0
69.00	06900	ELECTROCARDIOLOGY	0.338592	4,468
70.00	07000	ELECTROENCEPHALOGRAPHY	0.331330	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.264373	84,585
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.206816	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0.313951	334,800
74.00	07400	RENAL DIALYSIS	0.000000	0
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0
OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.374902	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.637048	0
200.00		Total (sum of lines 50-94 and 96-98)		1,425,480
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0
202.00		Net Charges (line 200 minus line 201)		1,425,480

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151301	Period: From 07/01/2012 To 06/30/2013	Worksheet E Part B Date/Time Prepared: 11/25/2013 3:32 pm
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		4,223,275	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	PPS payments		0	3.00
4.00	Outlier payment (see instructions)		0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from worksheet D, Part IV, column 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		4,223,275	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from worksheet D-4, Part III, line 69, col. 4)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)		4,265,508	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		0	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		31,029	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		2,631,588	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)		1,602,891	27.00
28.00	Direct graduate medical education payments (from worksheet E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from worksheet E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		1,602,891	30.00
31.00	Primary payer payments		197	31.00
32.00	Subtotal (line 30 minus line 31)		1,602,694	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)		521,673	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		521,673	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		248,952	36.00
37.00	Subtotal (see instructions)		2,124,367	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		2,124,367	40.00
40.01	Sequestration adjustment (see instructions)		10,622	40.01
41.00	Interim payments		1,708,698	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		405,047	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: 151301

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

Worksheet E-1
Part I
Date/Time Prepared:
11/25/2013 3:32 pm

		Title XVIII		Hospital		Cost	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		2,085,903		1,708,698	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	07/02/2012	39,643		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)		39,643		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)		2,125,546		1,708,698	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		308,298		415,669	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		2,433,844		2,124,367	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
			0	1.00	2.00		
8.00	Name of Contractor					8.00	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151301
Component CCN: 15z301

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

Worksheet E-1
Part I
Date/Time Prepared:
11/25/2013 3:32 pm

		Title XVIII		Swing Beds - SNF	Cost
		Inpatient Part A		Part B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount
		1.00	2.00	3.00	4.00
1.00	Total interim payments paid to provider		222,477		0
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
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)				
Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0
3.02			0		0
3.03			0		0
3.04			0		0
3.05			0		0
Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0
3.51			0		0
3.52			0		0
3.53			0		0
3.54			0		0
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0
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)		222,477		0
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)				
Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0
5.02			0		0
5.03			0		0
Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0
5.51			0		0
5.52			0		0
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				
6.01	SETTLEMENT TO PROVIDER		76,086		0
6.02	SETTLEMENT TO PROGRAM		0		0
7.00	Total Medicare program liability (see instructions)		298,563		0
				Contractor Number	NPR Date (Mo/Day/Yr)
				1.00	2.00
8.00	Name of Contractor		0		

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 151301	Period: From 07/01/2012	Worksheet E-2
		Component CCN: 15Z301	To 06/30/2013	Date/Time Prepared: 11/25/2013 3:32 pm
		Title XVIII	Swing Beds - SNF	Cost
			Part A	Part B
			1.00	2.00

COMPUTATION OF NET COST OF COVERED SERVICES				
		Part A	Part B	
		1.00	2.00	
1.00	Inpatient routine services - swing bed-SNF (see instructions)	215,762	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from wkst. D-3, column 3, line 200 for Part A, and sum of wkst. D, Part V, columns 5 and 7, line 202 for Part B) (For CAH, see instructions)	84,246	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	152	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	300,008	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	300,008	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	300,008	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	1,445	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	298,563	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	298,563	0	19.00
19.01	Sequestration adjustment (see instructions)	1,493	0	19.01
20.00	Interim payments	222,477	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program line 19 minus lines 19.01, 20 and 21	74,593	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151301	Period: From 07/01/2012 To 06/30/2013	Worksheet E-3 Part V Date/Time Prepared: 11/25/2013 3:32 pm
		Title XVIII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)				
1.00	Inpatient services			2,692,690 1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction)			0 2.00
3.00	Organ acquisition			0 3.00
4.00	Subtotal (sum of lines 1 thru 3)			2,692,690 4.00
5.00	Primary payer payments			0 5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			2,719,617 6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
7.00	Routine service charges			0 7.00
8.00	Ancillary service charges			0 8.00
9.00	Organ acquisition charges, net of revenue			0 9.00
10.00	Total reasonable charges			0 10.00
Customary charges				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0 12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.000000 13.00
14.00	Total customary charges (see instructions)			0 14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)			0 15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)			0 16.00
17.00	Cost of teaching physicians (from worksheet D-5, Part II, column 3, line 20) (see instructions)			0 17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from worksheet E-4, line 49)			0 18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)			2,719,617 19.00
20.00	Deductibles (exclude professional component)			310,716 20.00
21.00	Excess reasonable cost (from line 16)			0 21.00
22.00	Subtotal (line 19 minus line 20)			2,408,901 22.00
23.00	Coinsurance			888 23.00
24.00	Subtotal (line 22 minus line 23)			2,408,013 24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			25,831 25.00
26.00	Adjusted reimbursable bad debts (see instructions)			25,831 26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			6,540 27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)			2,433,844 28.00
29.00				0 29.00
29.99	Recovery of Accelerated Depreciation			0 29.99
30.00	Subtotal (line 28, plus or minus lines 29)			2,433,844 30.00
30.01	Sequestration adjustment (see instructions)			12,169 30.01
31.00	Interim payments			2,125,546 31.00
32.00	Tentative settlement (for contractor use only)			0 32.00
33.00	Balance due provider/program line 30 minus lines 30.01, 31, and 32			296,129 33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2			0 34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151301	Period: From 07/01/2012 To 06/30/2013	Worksheet E-3 Part VII Date/Time Prepared: 11/25/2013 3:32 pm	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		840,001		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)		840,001	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)		840,001	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		0		8.00
9.00	Ancillary service charges		1,425,480	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		1,425,480	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		1,425,480	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		585,479	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of Teaching Physicians (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		840,001	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0	0	24.00
25.00	Capital exception payments (see instructions)		0	0	25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		840,001	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)		840,001	0	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		840,001	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		840,001	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		840,001	0	40.00
41.00	Interim payments		840,001	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: 151301

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

Worksheet G

Date/Time Prepared:
11/25/2013 3:32 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	35,298	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	7,553,121	0	0	0	4.00
5.00	Other receivable	951,332	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-4,704,638	0	0	0	6.00
7.00	Inventory	283,964	0	0	0	7.00
8.00	Prepaid expenses	189,305	0	0	0	8.00
9.00	Other current assets	-65,263	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	4,243,119	0	0	0	11.00
FIXED ASSETS						
12.00	Land	696,652	0	0	0	12.00
13.00	Land improvements	25,100	0	0	0	13.00
14.00	Accumulated depreciation	-23,698	0	0	0	14.00
15.00	Buildings	18,048,925	0	0	0	15.00
16.00	Accumulated depreciation	-6,786,471	0	0	0	16.00
17.00	Leasehold improvements	1,707	0	0	0	17.00
18.00	Accumulated depreciation	-1,707	0	0	0	18.00
19.00	Fixed equipment	481,378	0	0	0	19.00
20.00	Accumulated depreciation	-445,282	0	0	0	20.00
21.00	Automobiles and trucks	12,322	0	0	0	21.00
22.00	Accumulated depreciation	-10,122	0	0	0	22.00
23.00	Major movable equipment	5,516,378	0	0	0	23.00
24.00	Accumulated depreciation	-4,763,035	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)	12,752,147	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	25,817,635	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	801,522	65,263	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	26,619,157	65,263	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	43,614,423	65,263	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,220,054	0	0	0	37.00
38.00	Salaries, wages, and fees payable	755,343	0	0	0	38.00
39.00	Payroll taxes payable	122,603	0	0	0	39.00
40.00	Notes and loans payable (short term)	209,066	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	2,434,476	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,741,542	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	14,314,793	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	487,599	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	14,802,392	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	19,543,934	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	24,070,489	0	0	0	52.00
53.00	Specific purpose fund	0	65,263	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)	24,070,489	65,263	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	43,614,423	65,263	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151301

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

Worksheet G-1

Date/Time Prepared:
11/25/2013 3:32 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		20,407,958		137,295		1.00
2.00	Net income (loss) (from wkst. G-3, line 29)		3,728,501				2.00
3.00	Total (sum of line 1 and line 2)		24,136,459		137,295		3.00
4.00	DEFERRED PENSION COST	-54,630		0		0	4.00
5.00	DONATIONS	98,482		61,019		0	5.00
6.00	OTHER	0		111,525		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		43,852		172,544		10.00
11.00	Subtotal (line 3 plus line 10)		24,180,311		309,839		11.00
12.00	TRANSFERS TO AFFILIATES	-7,256		0		0	12.00
13.00	OTHER PENSION RELATED ADJ	0		0		0	13.00
14.00	RELEASED OPERATING	0		244,576		0	14.00
15.00	RELEASED CAPITAL	117,078		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		109,822		244,576		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		24,070,489		65,263		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	DEFERRED PENSION COST		0				4.00
5.00	DONATIONS		0				5.00
6.00	OTHER		0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	TRANSFERS TO AFFILIATES		0				12.00
13.00	OTHER PENSION RELATED ADJ		0				13.00
14.00	RELEASED OPERATING		0				14.00
15.00	RELEASED CAPITAL		0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 151301

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
11/25/2013 3:32 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	4,968,593		4,968,593	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER	0		0	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)	4,968,593		4,968,593	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)	4,968,593		4,968,593	17.00
18.00	Ancillary services	8,576,838	47,264,037	55,840,875	18.00
19.00	Outpatient services	356,342	12,246,837	12,603,179	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		0	0	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	0	0	0	26.00
27.00	OTHER	0	17,520	17,520	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to wkst. G-3, line 1)	13,901,773	59,528,394	73,430,167	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per wkst. A, column 3, line 200)		24,930,495		29.00
30.00		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		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)		24,930,495		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 151301

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

Worksheet G-3

Date/Time Prepared:
11/25/2013 3:32 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	73,430,167	1.00
2.00	Less contractual allowances and discounts on patients' accounts	47,517,146	2.00
3.00	Net patient revenues (line 1 minus line 2)	25,913,021	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	24,930,495	4.00
5.00	Net income from service to patients (line 3 minus line 4)	982,526	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	40,776	6.00
7.00	Income from investments	1,002,849	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	0	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	0	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	OTHER	473,038	24.00
24.01	UNREALIZED GAINS	703,648	24.01
24.02	MISCELLANEOUS A&G	479,128	24.02
24.03	NET ASSETS RELEASED FROM RESTRICTION	49,624	24.03
24.04		0	24.04
24.05		0	24.05
25.00	Total other income (sum of lines 6-24)	2,749,063	25.00
26.00	Total (line 5 plus line 25)	3,731,589	26.00
27.00	LOSS ON INTEREST RATE SWAPS	3,088	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	3,088	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	3,728,501	29.00

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

Provider Name: ST. VINCENT RANDOLPH HOSPITAL

Health Financial Systems

Provider No: 151301

MCRIF32

Allocation of Physician Compensation: Hours

Department: ANESTHESIA

Provider: ST. VINCENT RANDOLPH HOSPITAL

Physician: AGGREGATE PHYSICIANS

Number: 151301

Specialty: ANESTHESIOLOGY-GENERAL

Basis of Allocation: Time Study

Describe:

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

Signature: Physician or Physician Department Head

Date

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Date Prepared: 11/25/2013 5:10:40 PM

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

Provider Name: ST. VINCENT RANDOLPH HOSPITAL

Health Financial Systems

Provider No: 151301

MCRIF32

Allocation of Physician Compensation: Hours

Department: ADULTS & PEDIATRICS

Provider: ST. VINCENT RANDOLPH HOSPITAL

Number: 151301

Physician: AGGREGATE PHYSICIANS

Specialty: INTERNAL MEDICINE-GENERAL

Basis of Allocation: Time Study

Describe:

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

Signature: Physician or Physician Department Head

Date

v7

Date Prepared: 11/25/2013 5:10:40 PM

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

Provider Name: ST. VINCENT RANDOLPH HOSPITAL

Health Financial Systems

Provider No: 151301

MCRIF32

Allocation of Physician Compensation: Hours

Department: PHYSICAL THERAPY

Provider: ST. VINCENT RANDOLPH HOSPITAL

Number: 151301

Physician: AGGREGATE PHYSICIANS

Specialty: REHABILITATION MEDICINE-GENERAL

Basis of Allocation: Time Study

Describe:

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

Signature: Physician or Physician Department Head

Date

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Date Prepared: 11/25/2013 5:10:40 PM

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

Provider Name: ST. VINCENT RANDOLPH HOSPITAL

Health Financial Systems

Provider No: 151301

MCRIF32

Allocation of Physician Compensation: Hours

Department: EMERGENCY DEPARTMENT

Provider: ST. VINCENT RANDOLPH HOSPITAL

Number: 151301

Physician: AGGREGATE PHYSICIANS

Specialty: EMERGENCY MEDICINE-GENERAL

Basis of Allocation: Time Study

Describe:

Services	Total Hours
1. Provider Services - Teaching and Supervision of I/R's and other GME Related Functions.	0.00
1A. Provider Services - Teaching and Supervision of Allied Health Students.	0.00
1B. Provider Services - Non Teaching Reimbursable Activities such as Department Administration, Supervision of Nursing, and Technical Staff, Utilization Review, etc.	0.00
1C. Provider Services - Emergency Room Physician Availability (Do not include minimum guarantee arrangements for Emergency Room Physicians.)	7732.45
1D. Sub-Total - Provider Administrative Services (Lines 1, 1A, 1B, 1C.)	7732.45
2. Physician Services: Medical and Surgical Services to Individual Patients.	1027.55
3. Non-Reimbursable Activities: Research, Teaching of I/R's in Non-Approved Programs, Teaching and Supervision of Medical Students, Writing for Medical Journals, etc.	0.00
4. Total Hours (Lines 1D, 2, and 3)	8760.00
5. Professional Component Percentage (Line 2 / Line 4)	11.73 %
6. Provider Component Percentage - (Line 1D / Line 4)	88.27 %

Signature: Physician or Physician Department Head

Date

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