

**St. Vincent Seton Specialty Hospital
Lafayette, IN**

**Medicare Provider No. 15-2021
and Medicaid Aim No. 200413490a**

**Hospital Statements of Reimbursable Costs
(Medicare and Medicaid Programs)**

June 30, 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: 152021 Period: From 07/01/2012 To 06/30/2013 Worksheet 5 Parts I-III Date/Time Prepared: 11/25/2013 11:57 am

PART I - COST REPORT STATUS

Provider use only 1. Electronically filed cost report Date: 11/25/2013 Time: 11:57 am
 2. Manually submitted cost report
 3. If this is an amended report enter the number of times the provider resubmitted this cost report
 4. Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only 5. Cost Report Status 6. Date Received:
 (1) As Submitted 7. Contractor No.
 (2) Settled without Audit 8. Initial Report for this Provider CCN
 (3) Settled with Audit 9. Final Report for this Provider CCN
 (4) Reopened
 (5) Amended

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above 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 SETON SPECIALTY HOSP-LAF (152021) 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: 11:57 am
 2U0Uu1tPpioFqJDQ0iAqNIyGv:3c0
 cbJnW03BB0em9RuEg2Vbv1f5PtUOrT
 6i5B0YP4zv0U.nhX
 PI: Date: 11/25/2013 Time: 11:57 am
 5LdPdI2LdAyIEwW37JdAdxw1ly7aK0
 1Nant0j3YS9dhmQdHkrHg7:yemZD93
 :w:80Fwfc60uksFI

(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	91,325	-4	0	0	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
5.00 Swing bed - SNF	0	0	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
200.00 Total	0	91,325	-4	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 152021	Period: From 07/01/2012 To 06/30/2013	Worksheet S-2 Part I Date/Time Prepared: 11/20/2013 3:50 pm
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1.00 Hospital and Hospital Health Care Complex Address:		2.00		3.00		4.00	
1.00	Street: 1501 HARTFORD STREET	PO Box:					
2.00	City: LAFAYETTE	State: IN		Zip Code: 47904		County: TIPPECANOE	

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)		
							V	XVIII	XIX
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00

3.00 Hospital and Hospital-Based Component Identification:										3.00
3.00	Hospital	ST VINCENT SETON SPECIALTY HOSP-LAF	152021	29140	2	02/07/2003	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 152021	Period: From 07/01/2012 To 06/30/2013	Worksheet S-2 Part I Date/Time Prepared: 11/20/2013 3:50 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.					57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete worksheet D-5.					58.00
59.00	Are costs claimed on line 100 of worksheet A? If yes, complete worksheet D-2, Part I.	N				59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N				60.00
		Y/N 1.00	IME 2.00	Direct GME 3.00	IME 4.00	Direct GME 5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00		
61.02	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		
61.03	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		
61.04	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		
61.05	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		
61.06	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		
			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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 152021

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

Worksheet S-2
Part I
Date/Time Prepared:
11/20/2013 3:50 pm

		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	2.00	3.00
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: 152021

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

Worksheet S-2
Part I
Date/Time Prepared:
11/20/2013 3:50 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	
67.00	Enter in column 1 the program name associated with each of your primary care programs in which you trained residents. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000			67.00
					1.00	2.00	3.00	
Inpatient Psychiatric Facility PPS								
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N				70.00
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)					0		71.00
Inpatient Rehabilitation Facility PPS								
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N				75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)					0		76.00
					1.00			
Long Term Care Hospital PPS								
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.					Y		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	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.			N		N		96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.				0.00		0.00	97.00
Rural Providers								
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?			N				105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)							106.00

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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)					107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		N			108.00
		Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					109.00
				1.00	2.00	3.00
Miscellaneous Cost Reporting Information						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.		N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.		N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.		Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		2			118.00
		Premiums 1.00	Losses 2.00	Insurance 3.00		
118.01	List amounts of malpractice premiums and paid losses:	14,375	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.		N			121.00
Transplant Center Information						
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00
All Providers						
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)		Y		15H046	140.00

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		1.00	2.00	3.00				
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.								
141.00	Name: ST. VINCENT HEALTH	Contractor's Name: WPS		Contractor's Number: 08101			141.00	
142.00	Street: 10330 N. MERIDIAN ST.	PO Box:					142.00	
143.00	City: INDIANAPOLIS	State: IN	Zip Code: 46290				143.00	
							1.00	
144.00	Are provider based physicians' costs included in worksheet A?						N	144.00
145.00	If costs for renal services are claimed on worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.						Y	145.00
							1.00	
							2.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.						N	146.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.						N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.						N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.						N	149.00
		Part A	Part B	Title V	Title XIX			
		1.00	2.00	3.00	4.00			
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)								
155.00	Hospital	N	N	N	N		155.00	
156.00	Subprovider - IPF	N	N	N	N		156.00	
157.00	Subprovider - IRF	N	N	N	N		157.00	
158.00	SUBPROVIDER						158.00	
159.00	SNF	N	N	N	N		159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N		160.00	
161.00	CMHC		N	N	N		161.00	
							1.00	
Multicampus								
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00	166.00
							1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act								
167.00	Is this provider a meaningful user under section §1886(n)? Enter "Y" for yes or "N" for no.						N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						0.00	168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.00	169.00
							Beginning	
							Ending	
							1.00	
							2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)							170.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 152021	Period: From 07/01/2012 To 06/30/2013	Worksheet S-2 Part II Date/Time Prepared: 11/20/2013 3:50 pm
		Y/N	Date	
		1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N	Date	V/I
		1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "v" for voluntary or "i" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N		3.00
		Y/N	Type	Date
		1.00	2.00	3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
		Y/N	Legal Oper.	
		1.00	2.00	
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N		9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on worksheet A? If yes, see instructions.	N		11.00
		Y/N		
		1.00		
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N	14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N	15.00
		Part A		Part B
Description		Y/N	Date	Y/N
0		1.00	2.00	3.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	10/02/2013	Y
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for other? Describe the other adjustments:	N		N

	Description	Part A		Part B	
		Y/N	Date	Y/N	
	0	1.00	2.00	3.00	
21.00	was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			N	33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			N	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N	35.00
				Y/N	Date
				1.00	2.00
Home Office Costs					
36.00	Were home office costs claimed on the cost report?			Y	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			Y	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N	40.00
				1.00	2.00
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	NANCY		GAYLE	41.00
42.00	Enter the employer/company name of the cost report preparer.	ST. VINCENT HEALTH			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-583-3236		NKGAYLE@STVINCENT.ORG	43.00

		Part B		
		Date		
		4.00		
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	10/02/2013		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.			19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.			21.00
			3.00	
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	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: 152021

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

Worksheet S-2
Part IX
Date/Time Prepared:
11/20/2013 3:50 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 152021

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

Worksheet S-3
Part I
Date/Time Prepared:
11/20/2013 3:50 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	Title V
	Line Number				Visits / Trips	
	1.00				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	29	10,585	0.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		29	10,585	0.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		29	10,585	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		29				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)	4,446	330	6,613			1.00
2.00 HMO and other (see instructions)	507	0				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0	0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	4,446	330	6,613			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)	4,446	330	6,613	0.00	86.87	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)				0.00	86.87	27.00
28.00 Observation Bed Days		0	0			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
33.00 LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 152021

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

Worksheet S-3
Part I
Date/Time Prepared:
11/20/2013 3:50 pm

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	147	7	220	1.00	
2.00 HMO and other (see instructions)			15			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	147	7	220	14.00	
15.00 CAH visits						15.00	
16.00 SUBPROVIDER - IPF						16.00	
17.00 SUBPROVIDER - IRF						17.00	
18.00 SUBPROVIDER						18.00	
19.00 SKILLED NURSING FACILITY						19.00	
20.00 NURSING FACILITY						20.00	
21.00 OTHER LONG TERM CARE						21.00	
22.00 HOME HEALTH AGENCY						22.00	
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00	
24.00 HOSPICE						24.00	
24.10 HOSPICE (non-distinct part)						24.10	
25.00 CMHC - CMHC						25.00	
26.00 RURAL HEALTH CLINIC						26.00	
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25	
27.00 Total (sum of lines 14-26)	0.00					27.00	
28.00 Observation Bed Days						28.00	
29.00 Ambulance Trips						29.00	
30.00 Employee discount days (see instruction)						30.00	
31.00 Employee discount days - IRF						31.00	
32.00 Labor & delivery days (see instructions)						32.00	
33.00 LTCH non-covered days						33.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 152021

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

Worksheet A

Date/Time Prepared:
11/20/2013 3:50 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		398,558	398,558	-16	398,542	1.00	
2.00	00200		406,024	406,024	0	406,024	2.00	
3.00	00300		0	0	0	0	3.00	
4.00	00400	149,740	1,437,438	1,587,178	0	1,587,178	4.00	
5.00	00500	827,657	778,841	1,606,498	16	1,606,514	5.00	
6.00	00600	0	0	0	0	0	6.00	
7.00	00700	45,151	122,446	167,597	0	167,597	7.00	
8.00	00800	0	47,068	47,068	0	47,068	8.00	
9.00	00900	0	4,024	4,024	0	4,024	9.00	
10.00	01000	0	104,154	104,154	0	104,154	10.00	
11.00	01100	0	0	0	0	0	11.00	
12.00	01200	0	0	0	0	0	12.00	
13.00	01300	407,777	32,428	440,205	0	440,205	13.00	
15.00	01500	345,424	595,249	940,673	0	940,673	15.00	
16.00	01600	19,194	42,944	62,138	0	62,138	16.00	
17.00	01700	57,315	0	57,315	0	57,315	17.00	
18.00	01850	49,458	-236	49,222	0	49,222	18.00	
19.00	01900	0	0	0	0	0	19.00	
20.00	02000	0	0	0	0	0	20.00	
21.00	02100	0	0	0	0	0	21.00	
22.00	02200	0	0	0	0	0	22.00	
23.00	02300	0	0	0	0	0	23.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	2,410,060	960,075	3,370,135	0	3,370,135	30.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	973	101,257	102,230	0	102,230	50.00	
51.00	05100	0	0	0	0	0	51.00	
52.00	05200	0	0	0	0	0	52.00	
53.00	05300	0	0	0	0	0	53.00	
54.00	05400	0	203,325	203,325	0	203,325	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	34,470	34,470	0	34,470	57.00	
58.00	05800	0	0	0	0	0	58.00	
59.00	05900	0	0	0	0	0	59.00	
60.00	06000	0	217,566	217,566	0	217,566	60.00	
60.01	06001	0	0	0	0	0	60.01	
61.00	06100	0	0	0	0	0	61.00	
62.00	06200	0	0	0	0	0	62.00	
63.00	06300	0	35,776	35,776	0	35,776	63.00	
64.00	06400	0	0	0	0	0	64.00	
65.00	06500	699,302	528,969	1,228,271	0	1,228,271	65.00	
66.00	06600	24,862	156,068	180,930	0	180,930	66.00	
67.00	06700	0	24,034	24,034	0	24,034	67.00	
68.00	06800	0	82,431	82,431	0	82,431	68.00	
69.00	06900	0	26,664	26,664	0	26,664	69.00	
70.00	07000	0	2,764	2,764	0	2,764	70.00	
71.00	07100	0	0	0	0	0	71.00	
72.00	07200	0	0	0	0	0	72.00	
73.00	07300	0	0	0	0	0	73.00	
74.00	07400	0	158,066	158,066	0	158,066	74.00	
75.00	07500	0	0	0	0	0	75.00	
OTHER REIMBURSABLE COST CENTERS								
100.00	10000	0	0	0	0	0	100.00	
SPECIAL PURPOSE COST CENTERS								
118.00	SUBTOTALS (SUM OF LINES 1-117)		5,036,913	6,500,403	11,537,316	0	11,537,316	118.00
NONREIMBURSABLE COST CENTERS								
193.00	19300	0	0	0	0	0	193.00	
194.00	07950	0	0	0	0	0	194.00	
194.01	07952	0	0	0	0	0	194.01	
200.00	TOTAL (SUM OF LINES 118-199)		5,036,913	6,500,403	11,537,316	0	11,537,316	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 152021

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

Worksheet A
Date/Time Prepared:
11/20/2013 3:50 pm

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation		
		6.00	7.00		
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	177,772	576,314	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	406,024	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	902,219	2,489,397	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	477,552	2,084,066	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700	OPERATION OF PLANT	-3,259	164,338	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	47,068	8.00
9.00	00900	HOUSEKEEPING	0	4,024	9.00
10.00	01000	DIETARY	0	104,154	10.00
11.00	01100	CAFETERIA	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	-11,440	428,765	13.00
15.00	01500	PHARMACY	-4,743	935,930	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-52,608	9,530	16.00
17.00	01700	SOCIAL SERVICE	0	57,315	17.00
18.00	01850	PASTORAL CARE	-49,458	-236	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-1,342	3,368,793	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	102,230	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	203,325	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	34,470	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	217,566	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	35,776	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	-486	1,227,785	65.00
66.00	06600	PHYSICAL THERAPY	0	180,930	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	24,034	67.00
68.00	06800	SPEECH PATHOLOGY	0	82,431	68.00
69.00	06900	ELECTROCARDIOLOGY	0	26,664	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,764	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	158,066	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	75.00
OTHER REIMBURSABLE COST CENTERS					
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	100.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,434,207	12,971,523	118.00
NONREIMBURSABLE COST CENTERS					
193.00	19300	NONPAID WORKERS	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.00
194.01	07952	MARKETING	85,883	85,883	194.01
200.00		TOTAL (SUM OF LINES 118-199)	1,520,090	13,057,406	200.00

Provider CCN: 152021

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

Worksheet A-6

Date/Time Prepared:
11/20/2013 3:50 pm

		Increases				
Cost Center		Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
A - INTEREST						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	16		1.00
	TOTALS		0	16		
500.00	Grand Total: Increases		0	16		500.00

Provider CCN: 152021

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

Worksheet A-6

Date/Time Prepared:
11/20/2013 3:50 pm

		Decreases					
	Cost Center	Line #	Salary	Other	wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - INTEREST						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	16	11		1.00
	TOTALS		0	16			
500.00	Grand Total: Decreases		0	16			500.00

Provider CCN: 152021

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

Worksheet A-6
Non-CMS Worksheet
Date/Time Prepared:
11/20/2013 3:50 pm

Increases			Decreases			
Cost Center	Line #	Salary	Cost Center	Line #	Salary	
2.00	3.00	4.00	6.00	7.00	8.00	
A - INTEREST						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	CAP REL COSTS-BLDG & FIXT	1.00	0 1.00
	TOTALS		0	TOTALS		0
500.00	Grand Total: Increases		0	Grand Total: Decreases		0 500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 152021

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

Worksheet A-7
Part I
Date/Time Prepared:
11/20/2013 3:50 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	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	3.00
4.00	Building Improvements	845,098	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	5.00
6.00	Movable Equipment	1,101,877	76,053	0	76,053	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	1,946,975	76,053	0	76,053	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	1,946,975	76,053	0	76,053	10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0			1.00
2.00	Land Improvements	0	0			2.00
3.00	Buildings and Fixtures	0	0			3.00
4.00	Building Improvements	845,098	0			4.00
5.00	Fixed Equipment	0	0			5.00
6.00	Movable Equipment	1,177,930	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	2,023,028	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	2,023,028	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 152021

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

Worksheet A-7
Part II
Date/Time Prepared:
11/20/2013 3:50 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	4,413	391,855	127	2,163	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	82,615	323,409	0	0	0	2.00
3.00	Total (sum of lines 1-2)	87,028	715,264	127	2,163	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	398,558				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	406,024				2.00
3.00	Total (sum of lines 1-2)	0	804,582				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 152021

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

Worksheet A-7
Part III
Date/Time Prepared:
11/20/2013 3:50 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	845,098	0	845,098	0.417739	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,177,930	0	1,177,930	0.582261	0	2.00
3.00	Total (sum of lines 1-2)	2,023,028	0	2,023,028	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	182,232	391,855	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	82,615	323,409	2.00
3.00	Total (sum of lines 1-2)	0	0	0	264,847	715,264	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	64	2,163	0	0	576,314	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	406,024	2.00
3.00	Total (sum of lines 1-2)	64	2,163	0	0	982,338	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)	B	-64	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)	B	-10	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	0			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	1,524,953			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-1,460	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00	23.00	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	24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00	25.00	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	NONPHYSICIAN ANESTHETISTS	19.00	28.00	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	30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00	30.99	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	31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	OTHER REV - CDM MAINTENANCE	B	-162	OPERATION OF PLANT	7.00	0	33.00
33.01	LOBBYING - NALTH	A	-1,088	ADMINISTRATIVE & GENERAL	5.00	0	33.01

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Provider CCN: 152021

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

Worksheet A-8

Date/Time Prepared:
11/20/2013 3:50 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		
33.02	LOBBYING - OTHER	A	-436	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	CHARITY/DONATIONS	A	-470	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	CHARITY/DONATIONS	A	-614	NURSING ADMINISTRATION	13.00	0	33.04
33.05	NON-REIMBURSABLE ALCOHOL	A	-2	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	LOSS ON SALE OF ASSETS	A	-557	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07			0		0.00	0	33.07
33.08			0		0.00	0	33.08
33.09			0		0.00	0	33.09
33.10			0		0.00	0	33.10
33.11			0		0.00	0	33.11
33.12			0		0.00	0	33.12
33.13			0		0.00	0	33.13
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200.)		1,520,090				50.00

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

Provider CCN: 152021

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

Worksheet A-8-1

Date/Time Prepared: 11/20/2013 3:50 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	1.00	CAP REL COSTS-BLDG & FIXT	ST. JOSEPH BLDG RENT	391,854	391,854 1.00
2.00	4.00	EMPLOYEE BENEFITS	EMPLOYEE BENEFITS	1,685,222	665,318 2.00
3.00	4.00	EMPLOYEE BENEFITS	EMPLOYEE BENEFITS - ST V CHARGEBACK	0	37,998 3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	ADMIN - ST V CHARGEBACK	0	86,496 4.00
4.01	7.00	OPERATION OF PLANT	ENGINEERING SVCS - ST V CHARGEBACK	0	4,260 4.01
4.02	13.00	NURSING ADMINISTRATION	NURSING ADMIN - ST V CHARGEBACK	0	10,826 4.02
4.03	15.00	PHARMACY	PHARMACY - ST V CHARGEBACK	0	4,743 4.03
4.04	16.00	MEDICAL RECORDS & LIBRARY	MEDICAL RECORDS - ST V CHARGEBACK	0	51,148 4.04
4.05	18.00	PASTORAL CARE	PASTORAL CARE - ST V CHARGEBACK	0	49,458 4.05
4.06	30.00	ADULTS & PEDIATRICS	ADULT & PEDS - ST V CHARGEBACK	0	1,342 4.06
4.07	65.00	RESPIRATORY THERAPY	RT - ST V CHARGEBACK	0	486 4.07
4.08	10.00	DIETARY	DIETARY - ST ELIZ CHARGEBACK	104,671	104,671 4.08
4.09	15.00	PHARMACY	PHARMACY - ST ELIZ CHARGEBACK	26,097	26,097 4.09
4.10	30.00	ADULTS & PEDIATRICS	ADULT & PEDS - ST ELIZ CHARGEBACK	13,017	13,017 4.10
4.11	50.00	OPERATING ROOM	OPERATING ROOM - ST ELIZ CHARGEBACK	100,397	100,397 4.11
4.12	54.00	RADIOLOGY-DIAGNOSTIC	RADIOLOGY - ST ELIZ CHARGEBACK	203,325	203,325 4.12
4.13	57.00	CT SCAN	CT SCAN - ST ELIZ CHARGEBACK	34,470	34,470 4.13
4.14	60.00	LABORATORY	LAB - ST ELIZ CHARGEBACK	102,249	102,249 4.14
4.15	63.00	BLOOD STORING, PROCESSING & TRANS.	BLOOD STORING - ST ELIZ CHARGEBACK	35,776	35,776 4.15
4.16	65.00	RESPIRATORY THERAPY	RT - ST ELIZ CHARGEBACK	30,231	30,231 4.16
4.17	66.00	PHYSICAL THERAPY	PT - ST ELIZ CHARGEBACK	154,720	154,720 4.17
4.18	67.00	OCCUPATIONAL THERAPY	OT - ST ELIZ CHARGEBACK	23,971	23,971 4.18
4.19	68.00	SPEECH PATHOLOGY	SP - ST ELIZ CHARGEBACK	82,431	82,431 4.19
4.20	69.00	ELECTROCARDIOLOGY	ELECTROCARD - ST ELIZ CHARGEBACK	26,664	26,664 4.20
4.21	70.00	ELECTROENCEPHALOGRAPHY	EEG - ST ELIZ CHARGEBACK	2,764	2,764 4.21
4.22	4.00	EMPLOYEE BENEFITS	ASCENSION BENEFITS	153,887	187,297 4.22
4.23	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE	177,883	0 4.23
4.24	194.01	MARKETING	HOME OFFICE	85,883	0 4.24
4.25	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	1,261,797	695,180 4.25
4.26	4.00	EMPLOYEE BENEFITS	HOME OFFICE	0	46,277 4.26
4.27	1.00	CAP REL COSTS-BLDG & FIXT	ASCENSION INTEREST	64	111 4.27
4.28	5.00	ADMINISTRATIVE & GENERAL	ASCENSION INTEREST	10	16 4.28
4.29	7.00	OPERATION OF PLANT	HOME OFFICE COSTS - TRIMEDIX	81,651	80,488 4.29
4.30	1.00	CAP REL COSTS-BLDG & FIXT	ASCENSION PAYMENTS	2,163	2,163 4.30
4.31	4.00	EMPLOYEE BENEFITS	ASCENSION PAYMENTS	60,178	60,178 4.31
4.32	5.00	ADMINISTRATIVE & GENERAL	ASCENSION PAYMENTS	31,210	31,210 4.32
5.00	0			4,872,585	3,347,632 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.

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 HEA	100.00	ST. VINCENT HEA	100.00	6.00
7.00	G	ASCENSION	100.00	ASCENSION	100.00	7.00
8.00	A	TRIMEDX	0.00	TRIMEDX	0.00	8.00

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

Provider CCN: 152021

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

Worksheet A-8-1

Date/Time Prepared:
11/20/2013 3:50 pm

	Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office		
				Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
9.00			0.00		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: 152021

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

worksheet A-8-1

Date/Time Prepared:
11/20/2013 3:50 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	0	10	1.00
2.00	1,019,904	0	2.00
3.00	-37,998	0	3.00
4.00	-86,496	0	4.00
4.01	-4,260	0	4.01
4.02	-10,826	0	4.02
4.03	-4,743	0	4.03
4.04	-51,148	0	4.04
4.05	-49,458	0	4.05
4.06	-1,342	0	4.06
4.07	-486	0	4.07
4.08	0	0	4.08
4.09	0	0	4.09
4.10	0	0	4.10
4.11	0	0	4.11
4.12	0	0	4.12
4.13	0	0	4.13
4.14	0	0	4.14
4.15	0	0	4.15
4.16	0	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
4.21	0	0	4.21
4.22	-33,410	0	4.22
4.23	177,883	9	4.23
4.24	85,883	0	4.24
4.25	566,617	0	4.25
4.26	-46,277	0	4.26
4.27	-47	11	4.27
4.28	-6	0	4.28
4.29	1,163	0	4.29
4.30	0	12	4.30
4.31	0	0	4.31
4.32	0	0	4.32
5.00	1,524,953	0	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	HOME OFFICE	6.00
7.00	HOME OFFICE	7.00
8.00	TECHNOLOGY MGMT	8.00
9.00		9.00
10.00		10.00
100.00		100.00

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

Provider CCN: 152021

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

Worksheet A-8-1

Date/Time Prepared:
11/20/2013 3:50 pm

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

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

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

Cost 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
GENERAL SERVICE COST CENTERS							
1.00 00100	CAP REL COSTS-BLDG & FIXT	576,314	576,314			1.00	
2.00 00200	CAP REL COSTS-MVBLE EQUIP	406,024		406,024		2.00	
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	2,489,397	0	0	2,489,397	4.00	
5.00 00500	ADMINISTRATIVE & GENERAL	2,084,066	90,127	63,496	421,587	5.00	
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00	
7.00 00700	OPERATION OF PLANT	164,338	7,721	5,440	22,999	7.00	
8.00 00800	LAUNDRY & LINEN SERVICE	47,068	12,725	8,965	0	8.00	
9.00 00900	HOUSEKEEPING	4,024	3,813	2,686	0	9.00	
10.00 01000	DIETARY	104,154	15,299	10,779	0	10.00	
11.00 01100	CAFETERIA	0	0	0	0	11.00	
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00	
13.00 01300	NURSING ADMINISTRATION	428,765	31,313	22,061	207,711	13.00	
15.00 01500	PHARMACY	935,930	24,450	17,225	175,950	15.00	
16.00 01600	MEDICAL RECORDS & LIBRARY	9,530	7,054	4,970	9,777	16.00	
17.00 01700	SOCIAL SERVICE	57,315	9,294	6,548	29,195	17.00	
18.00 01850	PASTORAL CARE	-236	0	0	25,193	18.00	
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00	
20.00 02000	NURSING SCHOOL	0	0	0	0	20.00	
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	21.00	
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	22.00	
23.00 02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	3,368,793	360,696	254,117	1,227,619	5,211,225	30.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	102,230	0	0	496	102,726	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	203,325	0	0	0	203,325	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	34,470	0	0	0	34,470	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	217,566	6,768	4,768	0	229,102	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0	60.01
61.00 06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	35,776	0	0	0	35,776	63.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	1,227,785	5,767	4,063	356,206	1,593,821	65.00
66.00 06600	PHYSICAL THERAPY	180,930	572	403	12,664	194,569	66.00
67.00 06700	OCCUPATIONAL THERAPY	24,034	429	302	0	24,765	67.00
68.00 06800	SPEECH PATHOLOGY	82,431	286	201	0	82,918	68.00
69.00 06900	ELECTROCARDIOLOGY	26,664	0	0	0	26,664	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	2,764	0	0	0	2,764	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	158,066	0	0	0	158,066	74.00
75.00 07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
OTHER REIMBURSABLE COST CENTERS							
100.00 10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	12,971,523	576,314	406,024	2,489,397	12,971,523	118.00
NONREIMBURSABLE COST CENTERS							
193.00 19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01 07952	MARKETING	85,883	0	0	0	85,883	194.01
200.00	Cross Foot Adjustments	0	0	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	13,057,406	576,314	406,024	2,489,397	13,057,406	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 152021

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

Worksheet B
Part I
Date/Time Prepared:
11/20/2013 3:50 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	2,659,276					5.00	
6.00	00600		0				6.00	
7.00	00700	51,277	0	251,775			7.00	
8.00	00800	17,585	0	6,696	93,039		8.00	
9.00	00900	2,691	0	2,006	0	15,220	9.00	
10.00	01000	33,306	0	8,051	0	504	10.00	
11.00	01100	0	0	0	0	0	11.00	
12.00	01200	0	0	0	0	0	12.00	
13.00	01300	176,426	0	16,477	0	1,032	13.00	
15.00	01500	295,017	0	12,866	0	806	15.00	
16.00	01600	8,013	0	3,712	0	232	16.00	
17.00	01700	26,176	0	4,891	0	306	17.00	
18.00	01850	6,383	0	0	0	0	18.00	
19.00	01900	0	0	0	0	0	19.00	
20.00	02000	0	0	0	0	0	20.00	
21.00	02100	0	0	0	0	0	21.00	
22.00	02200	0	0	0	0	0	22.00	
23.00	02300	0	0	0	0	0	23.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	1,332,744	0	189,803	93,039	11,885	30.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	26,272	0	0	0	0	50.00	
51.00	05100	0	0	0	0	0	51.00	
52.00	05200	0	0	0	0	0	52.00	
53.00	05300	0	0	0	0	0	53.00	
54.00	05400	52,000	0	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	8,816	0	0	0	0	57.00	
58.00	05800	0	0	0	0	0	58.00	
59.00	05900	0	0	0	0	0	59.00	
60.00	06000	58,592	0	3,561	0	223	60.00	
60.01	06001	0	0	0	0	0	60.01	
61.00	06100	0	0	0	0	0	61.00	
62.00	06200	0	0	0	0	0	62.00	
63.00	06300	9,150	0	0	0	0	63.00	
64.00	06400	0	0	0	0	0	64.00	
65.00	06500	407,613	0	3,035	0	190	65.00	
66.00	06600	49,760	0	301	0	19	66.00	
67.00	06700	6,334	0	226	0	14	67.00	
68.00	06800	21,206	0	150	0	9	68.00	
69.00	06900	6,819	0	0	0	0	69.00	
70.00	07000	707	0	0	0	0	70.00	
71.00	07100	0	0	0	0	0	71.00	
72.00	07200	0	0	0	0	0	72.00	
73.00	07300	0	0	0	0	0	73.00	
74.00	07400	40,425	0	0	0	0	74.00	
75.00	07500	0	0	0	0	0	75.00	
OTHER REIMBURSABLE COST CENTERS								
100.00	10000	0	0	0	0	0	100.00	
SPECIAL PURPOSE COST CENTERS								
118.00	SUBTOTALS (SUM OF LINES 1-117)		2,637,312	0	251,775	93,039	15,220	118.00
NONREIMBURSABLE COST CENTERS								
193.00	19300	0	0	0	0	0	193.00	
194.00	07950	0	0	0	0	0	194.00	
194.01	07952	21,964	0	0	0	0	194.01	
200.00	Cross Foot Adjustments		0	0	0	0	200.00	
201.00	Negative Cost Centers		0	0	0	0	201.00	
202.00	TOTAL (sum lines 118-201)		2,659,276	0	251,775	93,039	15,220	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 152021

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

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description		DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	PHARMACY		
		10.00	11.00	12.00	13.00	15.00		
GENERAL SERVICE COST CENTERS								
1.00	00100						1.00	
2.00	00200						2.00	
4.00	00400						4.00	
5.00	00500						5.00	
6.00	00600						6.00	
7.00	00700						7.00	
8.00	00800						8.00	
9.00	00900						9.00	
10.00	01000	172,093					10.00	
11.00	01100	0	0				11.00	
12.00	01200	0	0	0			12.00	
13.00	01300	0	0	0	883,785		13.00	
15.00	01500	0	0	0	0	1,462,244	15.00	
16.00	01600	0	0	0	0	0	16.00	
17.00	01700	0	0	0	0	0	17.00	
18.00	01850	0	0	0	0	0	18.00	
19.00	01900	0	0	0	0	0	19.00	
20.00	02000	0	0	0	0	0	20.00	
21.00	02100	0	0	0	0	0	21.00	
22.00	02200	0	0	0	0	0	22.00	
23.00	02300	0	0	0	0	0	23.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	172,093	0	0	681,687	0	30.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	0	0	0	240	0	50.00	
51.00	05100	0	0	0	0	0	51.00	
52.00	05200	0	0	0	0	0	52.00	
53.00	05300	0	0	0	0	0	53.00	
54.00	05400	0	0	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	0	0	0	0	57.00	
58.00	05800	0	0	0	0	0	58.00	
59.00	05900	0	0	0	0	0	59.00	
60.00	06000	0	0	0	0	0	60.00	
60.01	06001	0	0	0	0	0	60.01	
61.00	06100	0	0	0	0	0	61.00	
62.00	06200	0	0	0	0	0	62.00	
63.00	06300	0	0	0	0	0	63.00	
64.00	06400	0	0	0	0	0	64.00	
65.00	06500	0	0	0	186,607	0	65.00	
66.00	06600	0	0	0	15,251	0	66.00	
67.00	06700	0	0	0	0	0	67.00	
68.00	06800	0	0	0	0	0	68.00	
69.00	06900	0	0	0	0	0	69.00	
70.00	07000	0	0	0	0	0	70.00	
71.00	07100	0	0	0	0	0	71.00	
72.00	07200	0	0	0	0	0	72.00	
73.00	07300	0	0	0	0	1,462,244	73.00	
74.00	07400	0	0	0	0	0	74.00	
75.00	07500	0	0	0	0	0	75.00	
OTHER REIMBURSABLE COST CENTERS								
100.00	10000	0	0	0	0	0	100.00	
SPECIAL PURPOSE COST CENTERS								
118.00	SUBTOTALS (SUM OF LINES 1-117)		172,093	0	0	883,785	1,462,244	118.00
NONREIMBURSABLE COST CENTERS								
193.00	19300	0	0	0	0	0	193.00	
194.00	07950	0	0	0	0	0	194.00	
194.01	07952	0	0	0	0	0	194.01	
200.00	Cross Foot Adjustments						200.00	
201.00	Negative Cost Centers		0	0	0	0	201.00	
202.00	TOTAL (sum lines 118-201)		172,093	0	0	883,785	1,462,244	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN:152021

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

Worksheet B
Part I
Date/Time Prepared:
11/20/2013 3:50 pm

Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
			PASTORAL CARE			
	16.00	17.00	18.00	19.00	20.00	
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
15.00 01500	PHARMACY					15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	43,288				16.00
17.00 01700	SOCIAL SERVICE	0	133,725			17.00
18.00 01850	PASTORAL CARE	0	0	31,340		18.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00 02000	NURSING SCHOOL	0	0	0	0	20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	22.00
23.00 02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	16,414	133,725	31,340	0	30.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	1,202	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	807	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	479	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	4,272	0	0	0	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	60.01
61.00 06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	61.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	62.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	498	0	0	0	63.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	9,778	0	0	0	65.00
66.00 06600	PHYSICAL THERAPY	988	0	0	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	734	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	467	0	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY	588	0	0	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	14	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	6,089	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	958	0	0	0	74.00
75.00 07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
OTHER REIMBURSABLE COST CENTERS						
100.00 10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	100.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	43,288	133,725	31,340	0	118.00
NONREIMBURSABLE COST CENTERS						
193.00 19300	NONPAID WORKERS	0	0	0	0	193.00
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.00
194.01 07952	MARKETING	0	0	0	0	194.01
200.00	Cross Foot Adjustments	0	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	43,288	133,725	31,340	0	202.00

Cost Center Description	INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
	SERVICES-SALAR Y & FRINGES	SERVICES-OTHER PRGM COSTS				
	21.00	22.00				
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
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
18.00	01850	PASTORAL CARE				18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
20.00	02000	NURSING SCHOOL				20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	7,873,955
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	130,440
51.00	05100	RECOVERY ROOM	0	0	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0
53.00	05300	ANESTHESIOLOGY	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	256,132
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0
56.00	05600	RADIOISOTOPE	0	0	0	0
57.00	05700	CT SCAN	0	0	0	43,765
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0
60.00	06000	LABORATORY	0	0	0	295,750
60.01	06001	BLOOD LABORATORY	0	0	0	0
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	45,424
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,201,044
66.00	06600	PHYSICAL THERAPY	0	0	0	260,888
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	32,073
68.00	06800	SPEECH PATHOLOGY	0	0	0	104,750
69.00	06900	ELECTROCARDIOLOGY	0	0	0	34,071
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	3,485
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,468,333
74.00	07400	RENAL DIALYSIS	0	0	0	199,449
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0
OTHER REIMBURSABLE COST CENTERS						
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	0	0	12,949,559
NONREIMBURSABLE COST CENTERS						
193.00	19300	NONPAID WORKERS	0	0	0	0
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0
194.01	07952	MARKETING	0	0	0	107,847
200.00		Cross Foot Adjustments	0	0	0	0
201.00		Negative Cost Centers	0	0	0	0
202.00		TOTAL (sum lines 118-201)	0	0	0	13,057,406

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 152021

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

Worksheet B
Part I
Date/Time Prepared:
11/20/2013 3:50 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
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
18.00	01850	PASTORAL CARE	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
20.00	02000	NURSING SCHOOL	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	7,873,955
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	130,440
51.00	05100	RECOVERY ROOM	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0
53.00	05300	ANESTHESIOLOGY	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	256,132
55.00	05500	RADIOLOGY-THERAPEUTIC	0
56.00	05600	RADIOISOTOPE	0
57.00	05700	CT SCAN	43,765
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0
59.00	05900	CARDIAC CATHETERIZATION	0
60.00	06000	LABORATORY	295,750
60.01	06001	BLOOD LABORATORY	0
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	45,424
64.00	06400	INTRAVENOUS THERAPY	0
65.00	06500	RESPIRATORY THERAPY	2,201,044
66.00	06600	PHYSICAL THERAPY	260,888
67.00	06700	OCCUPATIONAL THERAPY	32,073
68.00	06800	SPEECH PATHOLOGY	104,750
69.00	06900	ELECTROCARDIOLOGY	34,071
70.00	07000	ELECTROENCEPHALOGRAPHY	3,485
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0
73.00	07300	DRUGS CHARGED TO PATIENTS	1,468,333
74.00	07400	RENAL DIALYSIS	199,449
75.00	07500	ASC (NON-DISTINCT PART)	0
OTHER REIMBURSABLE COST CENTERS			
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0
SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1-117)	12,949,559
NONREIMBURSABLE COST CENTERS			
193.00	19300	NONPAID WORKERS	0
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0
194.01	07952	MARKETING	107,847
200.00		Cross Foot Adjustments	0
201.00		Negative Cost Centers	0
202.00		TOTAL (sum lines 118-201)	13,057,406

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 152021

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

Worksheet B
Part II
Date/Time Prepared:
11/20/2013 3:50 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
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	0	90,127	63,496	153,623	5.00
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00 00700	OPERATION OF PLANT	0	7,721	5,440	13,161	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	12,725	8,965	21,690	8.00
9.00 00900	HOUSEKEEPING	0	3,813	2,686	6,499	9.00
10.00 01000	DIETARY	0	15,299	10,779	26,078	10.00
11.00 01100	CAFETERIA	0	0	0	0	11.00
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00 01300	NURSING ADMINISTRATION	0	31,313	22,061	53,374	13.00
15.00 01500	PHARMACY	0	24,450	17,225	41,675	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	7,054	4,970	12,024	16.00
17.00 01700	SOCIAL SERVICE	0	9,294	6,548	15,842	17.00
18.00 01850	PASTORAL CARE	0	0	0	0	18.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00 02000	NURSING SCHOOL	0	0	0	0	20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	22.00
23.00 02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	360,696	254,117	614,813	30.00
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	6,768	4,768	11,536	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	60.01
61.00 06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	61.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	62.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	0	5,767	4,063	9,830	65.00
66.00 06600	PHYSICAL THERAPY	0	572	403	975	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	429	302	731	67.00
68.00 06800	SPEECH PATHOLOGY	0	286	201	487	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
OTHER REIMBURSABLE COST CENTERS						
100.00 10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	100.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	576,314	406,024	982,338	118.00
NONREIMBURSABLE COST CENTERS						
193.00 19300	NONPAID WORKERS	0	0	0	0	193.00
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.00
194.01 07952	MARKETING	0	0	0	0	194.01
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	576,314	406,024	982,338	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 152021

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

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		ADMINISTRATIVE & GENERAL	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	153,623					5.00
6.00	00600	0	0				6.00
7.00	00700	2,962	0	16,123			7.00
8.00	00800	1,016	0	429	23,135		8.00
9.00	00900	155	0	128	0	6,782	9.00
10.00	01000	1,924	0	516	0	225	10.00
11.00	01100	0	0	0	0	0	11.00
12.00	01200	0	0	0	0	0	12.00
13.00	01300	10,192	0	1,055	0	460	13.00
15.00	01500	17,043	0	824	0	359	15.00
16.00	01600	463	0	238	0	104	16.00
17.00	01700	1,512	0	313	0	136	17.00
18.00	01850	369	0	0	0	0	18.00
19.00	01900	0	0	0	0	0	19.00
20.00	02000	0	0	0	0	0	20.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
23.00	02300	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	76,990	0	12,155	23,135	5,296	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	1,518	0	0	0	0	50.00
51.00	05100	0	0	0	0	0	51.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	3,004	0	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	509	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	3,385	0	228	0	99	60.00
60.01	06001	0	0	0	0	0	60.01
61.00	06100	0	0	0	0	0	61.00
62.00	06200	0	0	0	0	0	62.00
63.00	06300	529	0	0	0	0	63.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	23,547	0	194	0	85	65.00
66.00	06600	2,875	0	19	0	8	66.00
67.00	06700	366	0	14	0	6	67.00
68.00	06800	1,225	0	10	0	4	68.00
69.00	06900	394	0	0	0	0	69.00
70.00	07000	41	0	0	0	0	70.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
74.00	07400	2,335	0	0	0	0	74.00
75.00	07500	0	0	0	0	0	75.00
OTHER REIMBURSABLE COST CENTERS							
100.00	10000	0	0	0	0	0	100.00
SPECIAL PURPOSE COST CENTERS							
118.00		152,354	0	16,123	23,135	6,782	118.00
NONREIMBURSABLE COST CENTERS							
193.00	19300	0	0	0	0	0	193.00
194.00	07950	0	0	0	0	0	194.00
194.01	07952	1,269	0	0	0	0	194.01
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		153,623	0	16,123	23,135	6,782	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 152021

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

Worksheet B
Part II
Date/Time Prepared:
11/20/2013 3:50 pm

Cost Center Description		DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	PHARMACY		
		10.00	11.00	12.00	13.00	15.00		
GENERAL SERVICE COST CENTERS								
1.00	00100						1.00	
2.00	00200						2.00	
4.00	00400						4.00	
5.00	00500						5.00	
6.00	00600						6.00	
7.00	00700						7.00	
8.00	00800						8.00	
9.00	00900						9.00	
10.00	01000	28,743					10.00	
11.00	01100	0	0				11.00	
12.00	01200	0	0	0			12.00	
13.00	01300	0	0	0	65,081		13.00	
15.00	01500	0	0	0	0	59,901	15.00	
16.00	01600	0	0	0	0	0	16.00	
17.00	01700	0	0	0	0	0	17.00	
18.00	01850	0	0	0	0	0	18.00	
19.00	01900	0	0	0	0	0	19.00	
20.00	02000	0	0	0	0	0	20.00	
21.00	02100	0	0	0	0	0	21.00	
22.00	02200	0	0	0	0	0	22.00	
23.00	02300	0	0	0	0	0	23.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	28,743	0	0	50,198	0	30.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	0	0	0	18	0	50.00	
51.00	05100	0	0	0	0	0	51.00	
52.00	05200	0	0	0	0	0	52.00	
53.00	05300	0	0	0	0	0	53.00	
54.00	05400	0	0	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	0	0	0	0	57.00	
58.00	05800	0	0	0	0	0	58.00	
59.00	05900	0	0	0	0	0	59.00	
60.00	06000	0	0	0	0	0	60.00	
60.01	06001	0	0	0	0	0	60.01	
61.00	06100	0	0	0	0	0	61.00	
62.00	06200	0	0	0	0	0	62.00	
63.00	06300	0	0	0	0	0	63.00	
64.00	06400	0	0	0	0	0	64.00	
65.00	06500	0	0	0	13,742	0	65.00	
66.00	06600	0	0	0	1,123	0	66.00	
67.00	06700	0	0	0	0	0	67.00	
68.00	06800	0	0	0	0	0	68.00	
69.00	06900	0	0	0	0	0	69.00	
70.00	07000	0	0	0	0	0	70.00	
71.00	07100	0	0	0	0	0	71.00	
72.00	07200	0	0	0	0	0	72.00	
73.00	07300	0	0	0	0	59,901	73.00	
74.00	07400	0	0	0	0	0	74.00	
75.00	07500	0	0	0	0	0	75.00	
OTHER REIMBURSABLE COST CENTERS								
100.00	10000	0	0	0	0	0	100.00	
SPECIAL PURPOSE COST CENTERS								
118.00	SUBTOTALS (SUM OF LINES 1-117)		28,743	0	0	65,081	59,901	118.00
NONREIMBURSABLE COST CENTERS								
193.00	19300	0	0	0	0	0	193.00	
194.00	07950	0	0	0	0	0	194.00	
194.01	07952	0	0	0	0	0	194.01	
200.00	Cross Foot Adjustments						200.00	
201.00	Negative Cost Centers		0	0	0	0	201.00	
202.00	TOTAL (sum lines 118-201)		28,743	0	0	65,081	59,901	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 152021

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

Worksheet B
Part II
Date/Time Prepared:
11/20/2013 3:50 pm

Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE PASTORAL CARE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL		
	16.00	17.00	18.00	19.00	20.00		
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	
15.00 01500 PHARMACY						15.00	
16.00 01600 MEDICAL RECORDS & LIBRARY	12,829					16.00	
17.00 01700 SOCIAL SERVICE	0	17,803				17.00	
18.00 01850 PASTORAL CARE	0	0	366			18.00	
19.00 01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00	
20.00 02000 NURSING SCHOOL	0	0	0	0	0	20.00	
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0		21.00	
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0		22.00	
23.00 02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0		23.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000 ADULTS & PEDIATRICS	4,872	17,803	366			30.00	
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	356	0	0			50.00	
51.00 05100 RECOVERY ROOM	0	0	0			51.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0			52.00	
53.00 05300 ANESTHESIOLOGY	0	0	0			53.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	239	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	142	0	0			57.00	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0			58.00	
59.00 05900 CARDIAC CATHETERIZATION	0	0	0			59.00	
60.00 06000 LABORATORY	1,265	0	0			60.00	
60.01 06001 BLOOD LABORATORY	0	0	0			60.01	
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0			61.00	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0			62.00	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	148	0	0			63.00	
64.00 06400 INTRAVENOUS THERAPY	0	0	0			64.00	
65.00 06500 RESPIRATORY THERAPY	2,895	0	0			65.00	
66.00 06600 PHYSICAL THERAPY	293	0	0			66.00	
67.00 06700 OCCUPATIONAL THERAPY	217	0	0			67.00	
68.00 06800 SPEECH PATHOLOGY	138	0	0			68.00	
69.00 06900 ELECTROCARDIOLOGY	174	0	0			69.00	
70.00 07000 ELECTROENCEPHALOGRAPHY	4	0	0			70.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0			71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0			72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	1,802	0	0			73.00	
74.00 07400 RENAL DIALYSIS	284	0	0			74.00	
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0			75.00	
OTHER REIMBURSABLE COST CENTERS							
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0			100.00	
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)					0	118.00
	12,829	17,803	366				
NONREIMBURSABLE COST CENTERS							
193.00 19300 NONPAID WORKERS	0	0	0			193.00	
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0			194.00	
194.01 07952 MARKETING	0	0	0			194.01	
200.00	Cross Foot Adjustments					0	200.00
201.00	Negative Cost Centers					0	201.00
202.00	TOTAL (sum lines 118-201)					0	202.00
	12,829	17,803	369				

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 152021

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

Worksheet B
Part II
Date/Time Prepared:
11/20/2013 3:50 pm

Cost Center Description	INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
	SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS				
	21.00	22.00				
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
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
18.00	01850	PASTORAL CARE				18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
20.00	02000	NURSING SCHOOL				20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD		0		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)			0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS			834,371	0 30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM			1,892	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			3,243	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			651	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			16,513	0 60.00
60.01	06001	BLOOD LABORATORY			0	0 60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY			0	0 61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS			0	0 62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.			677	0 63.00
64.00	06400	INTRAVENOUS THERAPY			0	0 64.00
65.00	06500	RESPIRATORY THERAPY			50,293	0 65.00
66.00	06600	PHYSICAL THERAPY			5,293	0 66.00
67.00	06700	OCCUPATIONAL THERAPY			1,334	0 67.00
68.00	06800	SPEECH PATHOLOGY			1,864	0 68.00
69.00	06900	ELECTROCARDIOLOGY			568	0 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY			45	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			61,703	0 73.00
74.00	07400	RENAL DIALYSIS			2,619	0 74.00
75.00	07500	ASC (NON-DISTINCT PART)			0	0 75.00
OTHER REIMBURSABLE COST CENTERS						
100.00	10000	I&R SERVICES-NOT APPRVD PRGM			0	0 100.00
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	0	0	981,066 0 118.00
NONREIMBURSABLE COST CENTERS						
193.00	19300	NONPAID WORKERS			0	0 193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS			0	0 194.00
194.01	07952	MARKETING			1,269	0 194.01
200.00		Cross Foot Adjustments	0	0	0	0 200.00
201.00		Negative Cost Centers	0	0	3	0 201.00
202.00		TOTAL (sum lines 118-201)	0	0	0	982,338 0 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 152021

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

Worksheet B
Part II
Date/Time Prepared:
11/20/2013 3:50 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
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
18.00	01850	PASTORAL CARE	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
20.00	02000	NURSING SCHOOL	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	834,371
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	1,892
51.00	05100	RECOVERY ROOM	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0
53.00	05300	ANESTHESIOLOGY	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,243
55.00	05500	RADIOLOGY-THERAPEUTIC	0
56.00	05600	RADIOISOTOPE	0
57.00	05700	CT SCAN	651
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0
59.00	05900	CARDIAC CATHETERIZATION	0
60.00	06000	LABORATORY	16,513
60.01	06001	BLOOD LABORATORY	0
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	677
64.00	06400	INTRAVENOUS THERAPY	0
65.00	06500	RESPIRATORY THERAPY	50,293
66.00	06600	PHYSICAL THERAPY	5,293
67.00	06700	OCCUPATIONAL THERAPY	1,334
68.00	06800	SPEECH PATHOLOGY	1,864
69.00	06900	ELECTROCARDIOLOGY	568
70.00	07000	ELECTROENCEPHALOGRAPHY	45
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0
73.00	07300	DRUGS CHARGED TO PATIENTS	61,703
74.00	07400	RENAL DIALYSIS	2,619
75.00	07500	ASC (NON-DISTINCT PART)	0
OTHER REIMBURSABLE COST CENTERS			
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0
SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1-117)	981,066
NONREIMBURSABLE COST CENTERS			
193.00	19300	NONPAID WORKERS	0
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0
194.01	07952	MARKETING	1,269
200.00		Cross Foot Adjustments	0
201.00		Negative Cost Centers	3
202.00		TOTAL (sum lines 118-201)	982,338

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQARE FEET)	MVBLE EQUIP (SQARE FEET)					
	1.00	2.00	4.00				
GENERAL SERVICE COST CENTERS							
1.00 00100	CAP REL COSTS-BLDG & FIXT	12,092					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		12,092				2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	4,887,173			4.00
5.00 00500	ADMINISTRATIVE & GENERAL	1,891	1,891	827,657	-2,659,276	10,398,130	5.00
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00 00700	OPERATION OF PLANT	162	162	45,151	0	200,498	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	267	267	0	0	68,758	8.00
9.00 00900	HOUSEKEEPING	80	80	0	0	10,523	9.00
10.00 01000	DIETARY	321	321	0	0	130,232	10.00
11.00 01100	CAFETERIA	0	0	0	0	0	11.00
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00 01300	NURSING ADMINISTRATION	657	657	407,777	0	689,850	13.00
15.00 01500	PHARMACY	513	513	345,424	0	1,153,555	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	148	148	19,194	0	31,331	16.00
17.00 01700	SOCIAL SERVICE	195	195	57,315	0	102,352	17.00
18.00 01850	PASTORAL CARE	0	0	49,458	0	24,957	18.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00 02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00 02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	7,568	7,568	2,410,060	0	5,211,225	30.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	0	0	973	0	102,726	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	203,325	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	34,470	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	142	142	0	0	229,102	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0	60.01
61.00 06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	35,776	63.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	121	121	699,302	0	1,593,821	65.00
66.00 06600	PHYSICAL THERAPY	12	12	24,862	0	194,569	66.00
67.00 06700	OCCUPATIONAL THERAPY	9	9	0	0	24,765	67.00
68.00 06800	SPEECH PATHOLOGY	6	6	0	0	82,918	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	26,664	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	2,764	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	158,066	74.00
75.00 07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
OTHER REIMBURSABLE COST CENTERS							
100.00 10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	12,092	12,092	4,887,173	-2,659,276	10,312,247	118.00
NONREIMBURSABLE COST CENTERS							
193.00 19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01 07952	MARKETING	0	0	0	0	85,883	194.01
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per wkst. B, Part I)	576,314	406,024	2,489,397		2,659,276	202.00
203.00	Unit cost multiplier (wkst. B, Part I)	47.660767	33.577903	0.509374		0.255746	203.00
204.00	Cost to be allocated (per wkst. B, Part II)			0		153,623	204.00
205.00	Unit cost multiplier (wkst. B, Part II)			0.000000		0.014774	205.00

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COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 152021

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

Worksheet B-1

Date/Time Prepared:
11/20/2013 3:50 pm

Cost Center Description		MAINTENANCE & REPAIRS (SQ. FEET)	OPERATION OF PLANT (SQ. FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQ. FEET)	DIETARY (TOTAL PATIENT DAYS)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600	0					6.00
7.00	00700	0	10,039				7.00
8.00	00800	0	267	100			8.00
9.00	00900	0	80		9,692		9.00
10.00	01000	0	321	0	321	6,613	10.00
11.00	01100	0	0	0	0	0	11.00
12.00	01200	0	0	0	0	0	12.00
13.00	01300	0	657	0	657	0	13.00
15.00	01500	0	513	0	513	0	15.00
16.00	01600	0	148	0	148	0	16.00
17.00	01700	0	195	0	195	0	17.00
18.00	01850	0	0	0	0	0	18.00
19.00	01900	0	0	0	0	0	19.00
20.00	02000	0	0	0	0	0	20.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
23.00	02300	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	0	7,568	100	7,568	6,613	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	0	0	0	0	50.00
51.00	05100	0	0	0	0	0	51.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	0	0	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	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	0	142	0	142	0	60.00
60.01	06001	0	0	0	0	0	60.01
61.00	06100	0	0	0	0	0	61.00
62.00	06200	0	0	0	0	0	62.00
63.00	06300	0	0	0	0	0	63.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	0	121	0	121	0	65.00
66.00	06600	0	12	0	12	0	66.00
67.00	06700	0	9	0	9	0	67.00
68.00	06800	0	6	0	6	0	68.00
69.00	06900	0	0	0	0	0	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
74.00	07400	0	0	0	0	0	74.00
75.00	07500	0	0	0	0	0	75.00
OTHER REIMBURSABLE COST CENTERS							
100.00	10000	0	0	0	0	0	100.00
SPECIAL PURPOSE COST CENTERS							
118.00		0	10,039	100	9,692	6,613	118.00
NONREIMBURSABLE COST CENTERS							
193.00	19300	0	0	0	0	0	193.00
194.00	07950	0	0	0	0	0	194.00
194.01	07952	0	0	0	0	0	194.01
200.00							200.00
201.00							201.00
202.00		0	251,775	93,039	15,220	172,093	202.00
203.00		0.000000	25.079689	930.390000	1.570367	26.023439	203.00
204.00		0	16,123	23,135	6,782	28,743	204.00
205.00		0.000000	1.606036	231.350000	0.699752	4.346439	205.00

Cost Center Description		CAFETERIA (MEALS SERVED)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
		11.00	12.00	13.00	15.00	16.00		
GENERAL SERVICE COST CENTERS								
1.00	00100						1.00	
2.00	00200						2.00	
4.00	00400						4.00	
5.00	00500						5.00	
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	0					11.00	
12.00	01200	0	0				12.00	
13.00	01300	0	0	110,625			13.00	
15.00	01500	0	0	0	1,000		15.00	
16.00	01600	0	0	0	0	31,879,638	16.00	
17.00	01700	0	0	0	0	0	17.00	
18.00	01850	0	0	0	0	0	18.00	
19.00	01900	0	0	0	0	0	19.00	
20.00	02000	0	0	0	0	0	20.00	
21.00	02100	0	0	0	0	0	21.00	
22.00	02200	0	0	0	0	0	22.00	
23.00	02300	0	0	0	0	0	23.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	0	0	85,328	0	12,089,721	30.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	0	0	30	0	884,970	50.00	
51.00	05100	0	0	0	0	0	51.00	
52.00	05200	0	0	0	0	0	52.00	
53.00	05300	0	0	0	0	0	53.00	
54.00	05400	0	0	0	0	594,218	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	0	0	0	352,363	57.00	
58.00	05800	0	0	0	0	0	58.00	
59.00	05900	0	0	0	0	0	59.00	
60.00	06000	0	0	0	0	3,145,771	60.00	
60.01	06001	0	0	0	0	0	60.01	
61.00	06100	0	0	0	0	0	61.00	
62.00	06200	0	0	0	0	0	62.00	
63.00	06300	0	0	0	0	367,050	63.00	
64.00	06400	0	0	0	0	0	64.00	
65.00	06500	0	0	23,358	0	7,200,385	65.00	
66.00	06600	0	0	1,909	0	727,686	66.00	
67.00	06700	0	0	0	0	540,573	67.00	
68.00	06800	0	0	0	0	344,158	68.00	
69.00	06900	0	0	0	0	432,865	69.00	
70.00	07000	0	0	0	0	10,316	70.00	
71.00	07100	0	0	0	0	0	71.00	
72.00	07200	0	0	0	0	0	72.00	
73.00	07300	0	0	0	1,000	4,483,775	73.00	
74.00	07400	0	0	0	0	705,787	74.00	
75.00	07500	0	0	0	0	0	75.00	
OTHER REIMBURSABLE COST CENTERS								
100.00	10000	0	0	0	0	0	100.00	
SPECIAL PURPOSE COST CENTERS								
118.00	SUBTOTALS (SUM OF LINES 1-117)							118.00
NONREIMBURSABLE COST CENTERS								
193.00	19300	0	0	0	0	0	193.00	
194.00	07950	0	0	0	0	0	194.00	
194.01	07952	0	0	0	0	0	194.01	
200.00	Cross Foot Adjustments							200.00
201.00	Negative Cost Centers							201.00
202.00	Cost to be allocated (per wkst. B, Part I)							202.00
203.00	Unit cost multiplier (wkst. B, Part I)							203.00
204.00	Cost to be allocated (per wkst. B, Part II)							204.00
205.00	Unit cost multiplier (wkst. B, Part II)							205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 152021

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

Worksheet B-1

Date/Time Prepared:
11/20/2013 3:50 pm

Cost Center Description	SOCIAL SERVICE (TOTAL PATIENT DAYS)	OTHER GENERAL SERVICE	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS	
		PASTORAL CARE (TOTAL PATIENT DAYS)			SERVICES-SALAR Y & FRINGES (ASSIGNED TIME)	
	17.00	18.00	19.00	20.00	21.00	
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
15.00 01500	PHARMACY					15.00
16.00 01600	MEDICAL RECORDS & LIBRARY					16.00
17.00 01700	SOCIAL SERVICE	6,613				17.00
18.00 01850	PASTORAL CARE	0	6,613			18.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0		19.00
20.00 02000	NURSING SCHOOL	0	0	0	0	20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0		0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0			22.00
23.00 02300	PARAMED ED PRGM-(SPECIFY)	0	0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	6,613	6,613		0	30.00
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
60.01 06001	BLOOD LABORATORY	0	0	0	0	60.01
61.00 06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	61.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	62.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00 06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	68.00
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
OTHER REIMBURSABLE COST CENTERS						
100.00 10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	100.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	6,613	6,613	0	0	118.00
NONREIMBURSABLE COST CENTERS						
193.00 19300	NONPAID WORKERS	0	0	0	0	193.00
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.00
194.01 07952	MARKETING	0	0	0	0	194.01
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per wkst. B, Part I)	133,725	31,340	0	0	202.00
203.00	Unit cost multiplier (wkst. B, Part I)	20.221533	4.739150	0.000000	0.000000	203.00
204.00	Cost to be allocated (per wkst. B, Part II)	17,803	369	0	0	204.00
205.00	Unit cost multiplier (wkst. B, Part II)	2.692122	0.055346	0.000000	0.000000	205.00

	Cost Center Description	INTERNS & RESIDENTS	PARAMED ED PRGM (ASSIGNED TIME)	
		SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)		
		22.00		
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
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE		17.00
18.00	01850	PASTORAL CARE		18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS		19.00
20.00	02000	NURSING SCHOOL		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	30.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	50.00
51.00	05100	RECOVERY ROOM	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	52.00
53.00	05300	ANESTHESIOLOGY	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	55.00
56.00	05600	RADIOISOTOPE	0	56.00
57.00	05700	CT SCAN	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	59.00
60.00	06000	LABORATORY	0	60.00
60.01	06001	BLOOD LABORATORY	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	65.00
66.00	06600	PHYSICAL THERAPY	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	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
OTHER REIMBURSABLE COST CENTERS				
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	100.00
SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	118.00
NONREIMBURSABLE COST CENTERS				
193.00	19300	NONPAID WORKERS	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	194.00
194.01	07952	MARKETING	0	194.01
200.00		Cross Foot Adjustments		200.00
201.00		Negative Cost Centers		201.00
202.00		Cost to be allocated (per wkst. B, Part I)	0	202.00
203.00		Unit cost multiplier (wkst. B, Part I)	0.000000	203.00
204.00		Cost to be allocated (per wkst. B, Part II)	0	204.00
205.00		Unit cost multiplier (wkst. B, Part II)	0.000000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 152021

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

Worksheet C
Part I
Date/Time Prepared:
11/20/2013 3:50 pm

		Title XVIII		Hospital		PPS	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	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	7,873,955		7,873,955	0	7,873,955	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	130,440		130,440	0	130,440	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	256,132		256,132	0	256,132	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	43,765		43,765	0	43,765	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	295,750		295,750	0	295,750	60.00
60.01	06001 BLOOD LABORATORY	0		0	0	0	60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0		0	0	0	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0		0	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	45,424		45,424	0	45,424	63.00
64.00	06400 INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	2,201,044	0	2,201,044	0	2,201,044	65.00
66.00	06600 PHYSICAL THERAPY	260,888	0	260,888	0	260,888	66.00
67.00	06700 OCCUPATIONAL THERAPY	32,073	0	32,073	0	32,073	67.00
68.00	06800 SPEECH PATHOLOGY	104,750	0	104,750	0	104,750	68.00
69.00	06900 ELECTROCARDIOLOGY	34,071		34,071	0	34,071	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	3,485		3,485	0	3,485	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	1,468,333		1,468,333	0	1,468,333	73.00
74.00	07400 RENAL DIALYSIS	199,449		199,449	0	199,449	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0		0	0	0	75.00
OTHER REIMBURSABLE COST CENTERS							
100.00	10000 I&R SERVICES-NOT APPRVD PRGM	0		0	0	0	100.00
200.00	Subtotal (see instructions)	12,949,559	0	12,949,559	0	12,949,559	200.00
201.00	Less Observation Beds	0		0	0	0	201.00
202.00	Total (see instructions)	12,949,559	0	12,949,559	0	12,949,559	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 152021

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

Worksheet C
Part I
Date/Time Prepared:
11/20/2013 3:50 pm

		Title XVIII			Hospital	PPS
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
	9.00	10.00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,089,721		12,089,721	30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	884,970	0	884,970	0.147395
51.00	05100	RECOVERY ROOM	0	0	0	0.000000
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	588,373	5,845	594,218	0.431040
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0.000000
56.00	05600	RADIOISOTOPE	0	0	0	0.000000
57.00	05700	CT SCAN	349,165	3,198	352,363	0.124204
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000
60.00	06000	LABORATORY	3,145,491	280	3,145,771	0.094015
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0.000000
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0.000000
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	367,050	0	367,050	0.123754
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000
65.00	06500	RESPIRATORY THERAPY	7,158,234	42,151	7,200,385	0.305684
66.00	06600	PHYSICAL THERAPY	727,686	0	727,686	0.358517
67.00	06700	OCCUPATIONAL THERAPY	540,573	0	540,573	0.059331
68.00	06800	SPEECH PATHOLOGY	344,158	0	344,158	0.304366
69.00	06900	ELECTROCARDIOLOGY	432,865	0	432,865	0.078710
70.00	07000	ELECTROENCEPHALOGRAPHY	10,316	0	10,316	0.337825
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	4,483,775	0	4,483,775	0.327477
74.00	07400	RENAL DIALYSIS	705,787	0	705,787	0.282591
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000
OTHER REIMBURSABLE COST CENTERS						
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	
200.00		Subtotal (see instructions)	31,828,164	51,474	31,879,638	
201.00		Less Observation Beds				
202.00		Total (see instructions)	31,828,164	51,474	31,879,638	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 152021

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

Worksheet C
Part I
Date/Time Prepared:
11/20/2013 3:50 pm

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
INPATIENT ROUTINE SERVICE COST CENTERS		11.00			
30.00	03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.147395			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	0.431040			54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000			55.00
56.00	05600 RADIOISOTOPE	0.000000			56.00
57.00	05700 CT SCAN	0.124204			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	0.094015			60.00
60.01	06001 BLOOD LABORATORY	0.000000			60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000			61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000			62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.123754			63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000			64.00
65.00	06500 RESPIRATORY THERAPY	0.305684			65.00
66.00	06600 PHYSICAL THERAPY	0.358517			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.059331			67.00
68.00	06800 SPEECH PATHOLOGY	0.304366			68.00
69.00	06900 ELECTROCARDIOLOGY	0.078710			69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.337825			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	0.327477			73.00
74.00	07400 RENAL DIALYSIS	0.282591			74.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000			75.00
OTHER REIMBURSABLE COST CENTERS					
100.00	10000 I&R SERVICES-NOT APPRVD PRGM				100.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 152021

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

Worksheet C
Part I
Date/Time Prepared:
11/20/2013 3:50 pm

		Title XIX		Hospital		Cost	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	Total Costs	
			Total Costs	RCE Disallowance			
	1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	7,873,955		7,873,955	0	0	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	130,440		130,440	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	256,132		256,132	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	43,765		43,765	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	295,750		295,750	0	0	60.00
60.01	06001 BLOOD LABORATORY	0		0	0	0	60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0		0	0	0	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0		0	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	45,424		45,424	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	2,201,044	0	2,201,044	0	0	65.00
66.00	06600 PHYSICAL THERAPY	260,888	0	260,888	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	32,073	0	32,073	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	104,750	0	104,750	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	34,071		34,071	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	3,485		3,485	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	1,468,333		1,468,333	0	0	73.00
74.00	07400 RENAL DIALYSIS	199,449		199,449	0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0		0	0	0	75.00
OTHER REIMBURSABLE COST CENTERS							
100.00	10000 I&R SERVICES-NOT APPRVD PRGM	0		0	0	0	100.00
200.00	Subtotal (see instructions)	12,949,559	0	12,949,559	0	0	200.00
201.00	Less Observation Beds	0		0	0	0	201.00
202.00	Total (see instructions)	12,949,559	0	12,949,559	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 152021

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

Worksheet C
Part I
Date/Time Prepared:
11/20/2013 3:50 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	12,089,721		12,089,721	30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	884,970	0	884,970	0.147395 50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000 52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	588,373	5,845	594,218	0.431040 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	349,165	3,198	352,363	0.124204 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000 58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000 59.00
60.00	06000	LABORATORY	3,145,491	280	3,145,771	0.094015 60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000 60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0.000000 61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0.000000 62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	367,050	0	367,050	0.123754 63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000 64.00
65.00	06500	RESPIRATORY THERAPY	7,158,234	42,151	7,200,385	0.305684 65.00
66.00	06600	PHYSICAL THERAPY	727,686	0	727,686	0.358517 66.00
67.00	06700	OCCUPATIONAL THERAPY	540,573	0	540,573	0.059331 67.00
68.00	06800	SPEECH PATHOLOGY	344,158	0	344,158	0.304366 68.00
69.00	06900	ELECTROCARDIOLOGY	432,865	0	432,865	0.078710 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	10,316	0	10,316	0.337825 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,483,775	0	4,483,775	0.327477 73.00
74.00	07400	RENAL DIALYSIS	705,787	0	705,787	0.282591 74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000 75.00
OTHER REIMBURSABLE COST CENTERS						
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	100.00
200.00		Subtotal (see instructions)	31,828,164	51,474	31,879,638	200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)	31,828,164	51,474	31,879,638	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 152021

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

Worksheet C
Part I
Date/Time Prepared:
11/20/2013 3:50 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
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
60.01	06001 BLOOD LABORATORY	0.000000			60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000			61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000			62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000			63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000			64.00
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800 SPEECH PATHOLOGY	0.000000			68.00
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
OTHER REIMBURSABLE COST CENTERS					
100.00	10000 I&R SERVICES-NOT APPRVD PRGM				100.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 152021

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

Worksheet D
Part I
Date/Time Prepared:
11/20/2013 3:50 pm

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)	PPS
Title XVIII Hospital PPS							
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	834,371	0	834,371	6,613	126.17	30.00
200.00	Total (lines 30-199)	834,371		834,371	6,613		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	4,446	560,952				
200.00	Total (lines 30-199)	4,446	560,952				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 152021

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

Worksheet D
Part II
Date/Time Prepared:
11/20/2013 3:50 pm

Cost Center Description		Title XVIII			Hospital	PPS	
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	1,892	884,970	0.002138	573,107	1,225	50.00
51.00	05100 RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	3,243	594,218	0.005458	468,063	2,555	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	651	352,363	0.001848	200,204	370	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000 LABORATORY	16,513	3,145,771	0.005249	2,287,463	12,007	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0	0	60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0.000000	0	0	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.000000	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	677	367,050	0.001844	243,614	449	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	50,293	7,200,385	0.006985	5,333,827	37,257	65.00
66.00	06600 PHYSICAL THERAPY	5,293	727,686	0.007274	496,796	3,614	66.00
67.00	06700 OCCUPATIONAL THERAPY	1,334	540,573	0.002468	374,428	924	67.00
68.00	06800 SPEECH PATHOLOGY	1,864	344,158	0.005416	230,887	1,250	68.00
69.00	06900 ELECTROCARDIOLOGY	568	432,865	0.001312	87,051	114	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	45	10,316	0.004362	8,093	35	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	61,703	4,483,775	0.013761	3,114,383	42,857	73.00
74.00	07400 RENAL DIALYSIS	2,619	705,787	0.003711	487,455	1,809	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
200.00	Total (lines 50-199)	146,695	19,789,917		13,905,371	104,466	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 152021		Period: From 07/01/2012 To 06/30/2013		Worksheet D Part III Date/Time Prepared: 11/20/2013 3:50 pm	
Cost Center Description			Title XVIII			Hospital		PPS
			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
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	6,613	0.00	4,446	0	0	30.00
200.00		Total (lines 30-199)	6,613		4,446	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				
200.00		Total (lines 30-199)	0	0				

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 152021

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

Worksheet D
Part IV
Date/Time Prepared:
11/20/2013 3:50 pm

Cost Center Description	Title XVIII			Hospital	PPS	Total Cost (sum of col 1 through col. 4)	
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost			
	1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS							
50.00	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
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
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
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 152021	Period: From 07/01/2012 To 06/30/2013	Worksheet D Part IV Date/Time Prepared: 11/20/2013 3:50 pm
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Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital		Inpatient Program Charges	PPS	
				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)				
	6.00	7.00	8.00	9.00		10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	884,970	0.000000	0.000000	573,107	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	594,218	0.000000	0.000000	468,063	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	352,363	0.000000	0.000000	200,204	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	3,145,771	0.000000	0.000000	2,287,463	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0.000000	0.000000	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.000000	0.000000	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	367,050	0.000000	0.000000	243,614	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	7,200,385	0.000000	0.000000	5,333,827	65.00
66.00	06600	PHYSICAL THERAPY	0	727,686	0.000000	0.000000	496,796	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	540,573	0.000000	0.000000	374,428	67.00
68.00	06800	SPEECH PATHOLOGY	0	344,158	0.000000	0.000000	230,887	68.00
69.00	06900	ELECTROCARDIOLOGY	0	432,865	0.000000	0.000000	87,051	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	10,316	0.000000	0.000000	8,093	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,483,775	0.000000	0.000000	3,114,383	73.00
74.00	07400	RENAL DIALYSIS	0	705,787	0.000000	0.000000	487,455	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0.000000	0	75.00
200.00		Total (lines 50-199)	0	19,789,917			13,905,371	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 152021

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

Worksheet D
Part IV
Date/Time Prepared:
11/20/2013 3:50 pm

Cost Center Description		Title XVIII			Hospital	PPS	
		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	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	5,845	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	3,198	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	280	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	42,151	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
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
200.00		Total (lines 50-199)	0	51,474	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 152021	Period: From 07/01/2012 To 06/30/2013	Worksheet D Part IV Date/Time Prepared: 11/20/2013 3:50 pm
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Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	
		23.00	24.00	
ANCILLARY SERVICE COST CENTERS				
50.00	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
60.01	06001 BLOOD LABORATORY	0	0	60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	68.00
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
200.00	Total (lines 50-199)	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 152021

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

Worksheet D
Part V
Date/Time Prepared:
11/20/2013 3:50 pm

		Title XVIII			Hospital	PPS
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	0.147395	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	0.000000	0	0	0	0 52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	0	0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.431040	5,845	0	0	2,519 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	0.124204	3,198	0	0	397 57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0 58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0 59.00
60.00	06000 LABORATORY	0.094015	280	0	0	26 60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	0	0 60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	0	0	0 61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	0	0 62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.123754	0	0	0	0 63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	0	0 64.00
65.00	06500 RESPIRATORY THERAPY	0.305684	42,151	0	0	12,885 65.00
66.00	06600 PHYSICAL THERAPY	0.358517	0	0	0	0 66.00
67.00	06700 OCCUPATIONAL THERAPY	0.059331	0	0	0	0 67.00
68.00	06800 SPEECH PATHOLOGY	0.304366	0	0	0	0 68.00
69.00	06900 ELECTROCARDIOLOGY	0.078710	0	0	0	0 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.337825	0	0	0	0 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.327477	0	0	0	0 73.00
74.00	07400 RENAL DIALYSIS	0.282591	0	0	0	0 74.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000	0	0	0	0 75.00
200.00	Subtotal (see instructions)		51,474	0	0	15,827 200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	0 201.00
202.00	Net Charges (line 200 +/- line 201)		51,474	0	0	15,827 202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 152021	Period: From 07/01/2012 To 06/30/2013	Worksheet D Part V Date/Time Prepared: 11/20/2013 3:50 pm
Title XVIII		Hospital	PPS

Cost Center Description	Costs				
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
	6.00	7.00			
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	50.00
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
60.01	06001	BLOOD LABORATORY	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
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
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0	0	201.00
202.00		Net Charges (line 200 +/- line 201)	0	0	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 152021

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

Worksheet D
Part I
Date/Time Prepared:
11/20/2013 3:50 pm

Cost Center Description		Capital Related Cost (from wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	834,371	0	834,371	6,613	126.17	30.00
200.00	Total (lines 30-199)	834,371		834,371	6,613		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	330	41,636				
200.00	Total (lines 30-199)	330	41,636				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 152021

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

Worksheet D
Part II
Date/Time Prepared:
11/20/2013 3:50 pm

Cost Center Description		Title XIX			Hospital		Cost	
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,892	884,970	0.002138	4,761	10	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,243	594,218	0.005458	26,487	145	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	651	352,363	0.001848	16,451	30	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	16,513	3,145,771	0.005249	92,172	484	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0.000000	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.000000	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	677	367,050	0.001844	3,300	6	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	50,293	7,200,385	0.006985	253,231	1,769	65.00
66.00	06600	PHYSICAL THERAPY	5,293	727,686	0.007274	20,631	150	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,334	540,573	0.002468	16,216	40	67.00
68.00	06800	SPEECH PATHOLOGY	1,864	344,158	0.005416	13,635	74	68.00
69.00	06900	ELECTROCARDIOLOGY	568	432,865	0.001312	13,881	18	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	45	10,316	0.004362	986	4	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	61,703	4,483,775	0.013761	150,131	2,066	73.00
74.00	07400	RENAL DIALYSIS	2,619	705,787	0.003711	1,353	5	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
200.00		Total (lines 50-199)	146,695	19,789,917		613,235	4,801	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 152021		Period: From 07/01/2012 To 06/30/2013		Worksheet D Part III Date/Time Prepared: 11/20/2013 3:50 pm		
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
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	6,613	0.00	330	0	0	30.00
200.00		Total (lines 30-199)	6,613		330	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
200.00		Total (lines 30-199)	0	0				200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 152021

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

Worksheet D
Part IV
Date/Time Prepared:
11/20/2013 3:50 pm

Cost Center Description	Title XIX			Hospital	Cost		
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)		
	1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS							
50.00	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
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
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
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 152021

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

Worksheet D
Part IV
Date/Time Prepared:
11/20/2013 3:50 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	884,970	0.000000	0.000000	4,761	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	594,218	0.000000	0.000000	26,487	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	352,363	0.000000	0.000000	16,451	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	3,145,771	0.000000	0.000000	92,172	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0.000000	0.000000	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.000000	0.000000	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	367,050	0.000000	0.000000	3,300	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	7,200,385	0.000000	0.000000	253,231	65.00
66.00	06600	PHYSICAL THERAPY	0	727,686	0.000000	0.000000	20,631	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	540,573	0.000000	0.000000	16,216	67.00
68.00	06800	SPEECH PATHOLOGY	0	344,158	0.000000	0.000000	13,635	68.00
69.00	06900	ELECTROCARDIOLOGY	0	432,865	0.000000	0.000000	13,881	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	10,316	0.000000	0.000000	986	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,483,775	0.000000	0.000000	150,131	73.00
74.00	07400	RENAL DIALYSIS	0	705,787	0.000000	0.000000	1,353	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0.000000	0	75.00
200.00		Total (lines 50-199)	0	19,789,917			613,235	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 152021

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

Worksheet D
Part IV
Date/Time Prepared:
11/20/2013 3:50 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	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
60.01	06001 BLOOD LABORATORY	0	0	0	0	0	60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
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
200.00	Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 152021

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

Worksheet D
Part IV
Date/Time Prepared:
11/20/2013 3:50 pm

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
60.01	06001	BLOOD LABORATORY	0	0		60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0		61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
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
200.00		Total (lines 50-199)	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 152021	Period: From 07/01/2012 To 06/30/2013	Worksheet D-1 Date/Time Prepared: 11/20/2013 3:50 pm
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		6,613	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		6,613	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)		6,613	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		4,446	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		7,873,955	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		7,873,955	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)		7,873,955	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)		1,190.68	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		5,293,763	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		5,293,763	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 152021	Period: From 07/01/2012 To 06/30/2013	Worksheet D-1 Date/Time Prepared: 11/20/2013 3:50 pm
Cost Center Description			Title XVIII	Hospital	PPS
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)				42.00
Intensive Care Type Inpatient Hospital Units					
43.00	INTENSIVE CARE UNIT				43.00
44.00	CORONARY CARE UNIT				44.00
45.00	BURN INTENSIVE CARE UNIT				45.00
46.00	SURGICAL INTENSIVE CARE UNIT				46.00
47.00	OTHER SPECIAL CARE (SPECIFY)				47.00
Cost Center Description					1.00
48.00	Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)				3,624,587 48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				8,918,350 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)				560,952 50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from wkst. D, sum of Parts II and IV)				104,466 51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)				665,418 52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				8,252,932 53.00
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00	Program discharges				0 54.00
55.00	Target amount per discharge				0.00 55.00
56.00	Target amount (line 54 x line 55)				0 56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)				0 57.00
58.00	Bonus payment (see instructions)				0 58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket				0.00 59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket				0.00 60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)				0 61.00
62.00	Relief payment (see instructions)				0 62.00
63.00	Allowable inpatient cost plus incentive payment (see instructions)				0 63.00
PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)				0 64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)				0 65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)				0 66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)				0 67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)				0 68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)				0 69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY					
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)				70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)				71.00
72.00	Program routine service cost (line 9 x line 71)				72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)				73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)				74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from worksheet B, Part II, column 26, line 45)				75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)				76.00
77.00	Program capital-related costs (line 9 x line 76)				77.00
78.00	Inpatient routine service cost (line 74 minus line 77)				78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)				79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)				80.00
81.00	Inpatient routine service cost per diem limitation				81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)				82.00
83.00	Reasonable inpatient routine service costs (see instructions)				83.00
84.00	Program inpatient ancillary services (see instructions)				84.00
85.00	Utilization review - physician compensation (see instructions)				85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)				86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00	Total observation bed days (see instructions)				0 87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				0.00 88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				0 89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 152021

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

Worksheet D-1

Date/Time Prepared:
11/20/2013 3:50 pm

Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	PPS	
					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	834,371	7,873,955	0.105966	0	0	90.00
91.00 Nursing School cost	0	7,873,955	0.000000	0	0	91.00
92.00 Allied health cost	0	7,873,955	0.000000	0	0	92.00
93.00 All other Medical Education	0	7,873,955	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 152021

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

Worksheet D-1

Date/Time Prepared:
11/20/2013 3:50 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)			6,613 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			6,613 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)			6,613 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			0 5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			0 7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			330 9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			0 10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0 14.00
15.00	Total nursery days (title V or XIX only)			0 15.00
16.00	Nursery days (title V or XIX only)			0 16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			0.00 17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			0.00 18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			0.00 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			0.00 20.00
21.00	Total general inpatient routine service cost (see instructions)			7,873,955 21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)			0 22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)			0 23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			0 24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)			0 25.00
26.00	Total swing-bed cost (see instructions)			0 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			7,873,955 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)			7,873,955 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)			1,190.68 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			392,924 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)			392,924 41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 152021	Period: From 07/01/2012 To 06/30/2013	Worksheet D-1 Date/Time Prepared: 11/20/2013 3:50 pm		
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)					42.00
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT					43.00
44.00	CORONARY CARE UNIT					44.00
45.00	BURN INTENSIVE CARE UNIT					45.00
46.00	SURGICAL INTENSIVE CARE UNIT					46.00
47.00	OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description						1.00
48.00	Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					164,126 48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					557,050 49.00
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from wkst. D, sum of Parts I and III)					0 50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from wkst. D, sum of Parts II and IV)					0 51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0 52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0 53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0 54.00
55.00	Target amount per discharge					0.00 55.00
56.00	Target amount (line 54 x line 55)					0 56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0 57.00
58.00	Bonus payment (see instructions)					0 58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00 59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00 60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0 61.00
62.00	Relief payment (see instructions)					0 62.00
63.00	Allowable inpatient cost plus incentive payment (see instructions)					0 63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0 64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0 65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0 66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0 67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0 68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0 69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)					70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00	Program routine service cost (line 9 x line 71)					72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from worksheet B, Part II, column 26, line 45)					75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00	Program capital-related costs (line 9 x line 76)					77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00	Inpatient routine service cost per diem limitation					81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00	Reasonable inpatient routine service costs (see instructions)					83.00
84.00	Program inpatient ancillary services (see instructions)					84.00
85.00	Utilization review - physician compensation (see instructions)					85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)					0 87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00 88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0 89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 152021

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

Worksheet D-1
Date/Time Prepared:
11/20/2013 3:50 pm

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 152021	Period: From 07/01/2012 To 06/30/2013	Worksheet D-3	
Title XVIII		Hospital		PPS	
Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)		
	1.00	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		8,025,322		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.147395	573,107	84,473	50.00
51.00	05100 RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.431040	468,063	201,754	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	0.124204	200,204	24,866	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000 LABORATORY	0.094015	2,287,463	215,056	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	0	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.123754	243,614	30,148	63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.305684	5,333,827	1,630,466	65.00
66.00	06600 PHYSICAL THERAPY	0.358517	496,796	178,110	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.059331	374,428	22,215	67.00
68.00	06800 SPEECH PATHOLOGY	0.304366	230,887	70,274	68.00
69.00	06900 ELECTROCARDIOLOGY	0.078710	87,051	6,852	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.337825	8,093	2,734	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.327477	3,114,383	1,019,889	73.00
74.00	07400 RENAL DIALYSIS	0.282591	487,455	137,750	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
200.00	Total (sum of lines 50-94 and 96-98)		13,905,371	3,624,587	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		13,905,371		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 152021	Period: From 07/01/2012 To 06/30/2013	Worksheet D-3 Date/Time Prepared: 11/20/2013 3:50 pm
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		587,600	30.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.147395	4,761	702 50.00
51.00	05100 RECOVERY ROOM	0.000000	0	0 51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0 52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.431040	26,487	11,417 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	0.124204	16,451	2,043 57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0 58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0 59.00
60.00	06000 LABORATORY	0.094015	92,172	8,666 60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0 60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	0 61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0 62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.123754	3,300	408 63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0 64.00
65.00	06500 RESPIRATORY THERAPY	0.305684	253,231	77,409 65.00
66.00	06600 PHYSICAL THERAPY	0.358517	20,631	7,397 66.00
67.00	06700 OCCUPATIONAL THERAPY	0.059331	16,216	962 67.00
68.00	06800 SPEECH PATHOLOGY	0.304366	13,635	4,150 68.00
69.00	06900 ELECTROCARDIOLOGY	0.078710	13,881	1,093 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.337825	986	333 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.327477	150,131	49,164 73.00
74.00	07400 RENAL DIALYSIS	0.282591	1,353	382 74.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000	0	0 75.00
200.00	Total (sum of lines 50-94 and 96-98)		613,235	164,126 200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00	Net Charges (line 200 minus line 201)		613,235	164,126 202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 152021	Period: From 07/01/2012 To 06/30/2013	Worksheet E Part B Date/Time Prepared: 11/20/2013 3:50 pm
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPI (see instructions)		15,827	2.00
3.00	PPS payments		1,128	3.00
4.00	Outlier payment (see instructions)		990	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from worksheet D, Part IV, column 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from worksheet D-4, Part III, line 69, col. 4)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)		0	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		2,118	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		291	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)		1,827	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)		1,827	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		1,827	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from worksheet I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		1,827	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00			0	39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		1,827	40.00
40.01	Sequestration adjustment (see instructions)		9	40.01
41.00	Interim payments		1,822	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-4	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: 152021

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

Worksheet E-1
Part I
Date/Time Prepared:
11/20/2013 3:50 pm

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		7,010,390		1,822	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0		3.01
3.02			0		0		3.02
3.03			0		0		3.03
3.04			0		0		3.04
3.05			0		0		3.05
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0		3.50
3.51			0		0		3.51
3.52			0		0		3.52
3.53			0		0		3.53
3.54			0		0		3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0		3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to wkst. E or wkst. E-3, line and column as appropriate)		7,010,390		1,822	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		127,012		5	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		7,137,402		1,827	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor						8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 152021	Period: From 07/01/2012 To 06/30/2013	Worksheet E-3 Part IV Date/Time Prepared: 11/20/2013 3:50 pm
		Title XVIII	Hospital	PPS
		1.00		
PART IV - MEDICARE PART A SERVICES - LTCH PPS				
1.00	Net Federal PPS Payments (see instructions)		5,956,481	1.00
2.00	Outlier Payments		1,583,276	2.00
3.00	Total PPS Payments (sum of lines 1 and 2)		7,539,757	3.00
4.00	Nursing and Allied Health Managed Care payments (see instructions)		0	4.00
5.00	Organ acquisition (DO NOT USE THIS LINE)		0	5.00
6.00	Cost of teaching physicians		0	6.00
7.00	Subtotal (see instructions)		7,539,757	7.00
8.00	Primary payer payments		0	8.00
9.00	Subtotal (line 7 less line 8).		7,539,757	9.00
10.00	Deductibles		10,432	10.00
11.00	Subtotal (line 9 minus line 10)		7,529,325	11.00
12.00	Coinsurance		485,619	12.00
13.00	Subtotal (line 11 minus line 12)		7,043,706	13.00
14.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		133,851	14.00
15.00	Adjusted reimbursable bad debts (see instructions)		93,696	15.00
16.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		131,563	16.00
17.00	Subtotal (sum of lines 13 and 15)		7,137,402	17.00
18.00	Direct graduate medical education payments (from worksheet E-4, line 49)		0	18.00
19.00	Other pass through costs (see instructions)		0	19.00
20.00	Outlier payments reconciliation		0	20.00
21.00			0	21.00
21.99	Recovery of Accelerated Depreciation		0	21.99
22.00	Total amount payable to the provider (see instructions)		7,137,402	22.00
22.01	Sequestration adjustment (see instructions)		35,687	22.01
23.00	Interim payments		7,010,390	23.00
24.00	Tentative settlement (for contractor use only)		0	24.00
25.00	Balance due provider/program (line 22 minus lines 22.01, 23 and 24)		91,325	25.00
26.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		0	26.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from worksheet E-3, Part IV, line 2		0	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)		0	51.00
52.00	The rate used to calculate the Time Value of Money		0.00	52.00
53.00	Time value of Money (see instructions)		0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 152021	Period: From 07/01/2012 To 06/30/2013	Worksheet E-3 Part VII Date/Time Prepared: 11/20/2013 3:50 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		557,050		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)		557,050	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)		557,050	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		587,600		8.00
9.00	Ancillary service charges		613,235	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)		1,200,835	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)		1,200,835	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		643,785	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)		557,050	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)		557,050	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)		557,050	0	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinsurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		557,050	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		557,050	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)		557,050	0	40.00
41.00	Interim payments		557,050	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: 152021

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

Worksheet G

Date/Time Prepared:
11/20/2013 3:50 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	1,220,036	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	2,949,019	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-1,386,418	0	0	0	6.00
7.00	Inventory	127,737	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	10,005,977	104	0	0	9.00
10.00	Due from other funds	87,055	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	13,003,406	104	0	0	11.00
FIXED ASSETS						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	0	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	845,098	0	0	0	17.00
18.00	Accumulated depreciation	-832,868	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	1,177,930	0	0	0	23.00
24.00	Accumulated depreciation	-913,055	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)	277,105	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	13,280,511	104	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	257,252	0	0	0	37.00
38.00	Salaries, wages, and fees payable	297,348	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	2,323,395	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2,877,995	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	3,601	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	3,601	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	2,881,596	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	10,398,915	0	0	0	52.00
53.00	Specific purpose fund	0	104	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)	10,398,915	104	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	13,280,511	104	0	0	60.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 152021

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
11/20/2013 3:50 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	12,089,721		12,089,721	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	12,089,721		12,089,721	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	12,089,721		12,089,721	17.00
18.00	Ancillary services	19,738,443	51,474	19,789,917	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to wkst. G-3, line 1)	31,828,164	51,474	31,879,638	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per wkst. A, column 3, line 200)		11,537,316		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)		11,537,316		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 152021

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

Worksheet G-3

Date/Time Prepared:
11/20/2013 3:50 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	31,879,638	1.00
2.00	Less contractual allowances and discounts on patients' accounts	19,020,884	2.00
3.00	Net patient revenues (line 1 minus line 2)	12,858,754	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	11,537,316	4.00
5.00	Net income from service to patients (line 3 minus line 4)	1,321,438	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	14,340	6.00
7.00	Income from investments	407,252	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	1,460	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MAINTENANCE REV	162	24.00
24.01	ASSETS RELEASED FROM RESTRICTIONS	2,789	24.01
24.02	UNREALIZED GAIN	260,053	24.02
24.03		0	24.03
25.00	Total other income (sum of lines 6-24)	686,056	25.00
26.00	Total (line 5 plus line 25)	2,007,494	26.00
27.00	NON CASH FUNDED PENSION CURTAILMENT	19,093	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	19,093	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,988,401	29.00