

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: 152020	Period: From 07/01/2013 To 06/30/2014	Worksheet S Parts I-III Date/Time Prepared: 11/21/2014 9:05 am
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**PART I - COST REPORT STATUS**

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 11/21/2014 Time: 9:05 am
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

**PART II - CERTIFICATION**

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST VINCENT SETON SPECIALTY HOSP INDY ( 152020 ) for the cost reporting period beginning 07/01/2013 and ending 06/30/2014 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.

(Signed) \_\_\_\_\_  
Officer or Administrator of Provider(s)

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	99,730	10	0	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
200.00 Total	0	99,730	10	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. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 152020	Period: From 07/01/2013 To 06/30/2014	Worksheet S-2 Part I Date/Time Prepared: 11/19/2014 12:21 pm
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1.00	2.00	3.00	4.00	1.00	2.00
Hospital and Hospital Health Care Complex Address:					
Street: 8050 TOWNSHIP LINE ROAD		PO Box:		1.00	
City: INDIANAPOLIS		State: IN		2.00	
		Zip Code: 46260		County: MARI ON	

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

Hospital and Hospital -Based Component Identification:										
3.00	Hospital	ST VINCENT SETON SPECIALTY HOSP INDY	152020	26900	2	02/08/2003	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)					07/01/2013	06/30/2014	20.00	
21.00	Type of Control (see instructions)					1		21.00	

Inpatient PPS Information									
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	N	22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)							22.01	
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 days	Medicaid HMO days	Other Medicaid days	

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: 152020	Period: From 07/01/2013 To 06/30/2014	Worksheet S-2 Part I Date/Time Prepared: 11/19/2014 12:21 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		
<b>Prospective Payment System (PPS)-Capital</b>						
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
<b>Teaching Hospitals</b>						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N				56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.					57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.					58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N				59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N				60.00
		Y/N 1.00	IME 2.00	Direct GME 3.00	IME 4.00	Direct GME 5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00		61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00		61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00		61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00		61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00		61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00		61.06
		Program Name 1.00	Program Code 2.00	Unweighted IME FTE Count 3.00	Unweighted Direct GME FTE Count 4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.10

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	Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
	1.00	2.00	3.00	4.00	
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.		0.00	0.00	61.20
				1.00	
<u>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</u>					
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
<u>Teaching Hospitals that Claim Residents in Non-Provider Settings</u>					
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 Nonprovi der Site	Unweighted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))
			1.00	2.00	3.00
<u>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.</u>					
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	64.00
			Unweighted FTEs Nonprovi der Site	Unweighted FTEs in Hospi tal	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	65.00
			Unweighted FTEs Nonprovi der Site	Unweighted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))
			1.00	2.00	3.00
<u>Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010</u>					
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	66.00

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	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
<b>Inpatient Psychiatric Facility PPS</b>							
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 an approved GME 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
<b>Inpatient Rehabilitation Facility PPS</b>							
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 an approved GME 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		
<b>Long Term Care Hospital PPS</b>							
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.					Y	80.00
<b>TEFRA Providers</b>							
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	
<b>Title V and XIX Services</b>							
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
<b>Rural Providers</b>							
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)			N			106.00

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		V 1.00	XIX 2.00		
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N	N	107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00	
		Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.				109.00
				1.00	2.00
					3.00
<b>Miscellaneous Cost Reporting Information</b>					
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:	11,447	0	0	
				1.00	2.00
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.	N	N		120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N			121.00
<b>Transplant Center Information</b>					
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
<b>All Providers</b>					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y			140.00

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1.00		2.00		3.00		
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.						
141.00	Name: ST. VINCENT HEALTH	Contractor's Name: WPS		Contractor's Number: 08101		141.00
142.00	Street: 10330 N. MERIDIAN ST	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 1.00	Part B 2.00	Title V 3.00	Title XIX 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	
Multi campus			
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N	165.00

		Name 0	County 1.00	State 2.00	Zip Code 3.00	CBSA 4.00	FTE/Campus 5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00	166.00

		1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act			
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.	N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)		0.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)		0.00

		1.00	2.00	
170.00		Beginni ng	Endi ng	
Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)		1.00	2.00	170.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 152020	Period: From 07/01/2013 To 06/30/2014	Worksheet S-2 Part II Date/Time Prepared: 11/19/2014 12:21 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	10/21/2014	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 152020	Period: From 07/01/2013 To 06/30/2014	Worksheet S-2 Part II Date/Time Prepared: 11/19/2014 12:21 pm
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	Description	Part A		Part B	
		Y/N	Date	Y/N	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	1.00 N	2.00	3.00 N	21.00
				1.00	
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>					
<b>Capital Related Cost</b>					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
<b>Interest Expense</b>					
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			Y	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
<b>Purchased Services</b>					
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
<b>Provider-Based Physicians</b>					
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
<b>Home Office Costs</b>					
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
<b>Cost Report Preparer Contact Information</b>					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	JILL		HILL	41.00
42.00	Enter the employer/company name of the cost report preparer.	ST. VINCENT HEALTH			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-583-3519		JILL.HILL@STVINCENT.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 152020	Period: From 07/01/2013 To 06/30/2014	Worksheet S-2 Part II Date/Time Prepared: 11/19/2014 12:21 pm
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		Part B		
		Date		
		4.00		
<b>PS&amp;R Data</b>				
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)	10/21/2014		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	
<b>Cost Report Preparer Contact Information</b>				
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 152020

Period:  
From 07/01/2013  
To 06/30/2014

Worksheet S-3  
Part I  
Date/Time Prepared:  
11/19/2014 12:21 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits / Trips	Title V
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	74	27,010	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)		74	27,010	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)		74	27,010	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)		74				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)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 152020

Period:  
From 07/01/2013  
To 06/30/2014

Worksheet S-3  
Part I  
Date/Time Prepared:  
11/19/2014 12:21 pm

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)	13,656	842	22,113			1.00
2.00 HMO and other (see instructions)	2,091	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			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	13,656	842	22,113			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)	13,656	842	22,113	0.00	295.92	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	295.92	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)			77			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 152020

Period:  
From 07/01/2013  
To 06/30/2014

Worksheet S-3  
Part I  
Date/Time Prepared:  
11/19/2014 12:21 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	393	21	621	1.00
2.00 HMO and other (see instructions)			52	0		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	393	21	621	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
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES		Provider CCN: 152020		Period: From 07/01/2013 To 06/30/2014		Worksheet A			
Date/Time Prepared: 11/19/2014 12:21 pm									
Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassified (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)			
		1.00	2.00	3.00	4.00	5.00			
<b>GENERAL SERVICE COST CENTERS</b>									
1.00	00100	CAP REL COSTS-BLDG & FIXT		975,655		975,655	-1,351	974,304	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,147,419		1,147,419	0	1,147,419	2.00
3.00	00300	OTHER CAP REL COSTS		0		0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,141,027	5,011,806	6,152,833	0	6,152,833	4,301,638	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,375,078	1,925,209	4,300,287	1,351	4,301,638	0	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	355,250	1,457,669	1,812,919	0	1,812,919	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	136,221	136,221	0	136,221	0	8.00
9.00	00900	HOUSEKEEPING	0	405,523	405,523	0	405,523	0	9.00
10.00	01000	DIETARY	0	706,113	706,113	0	706,113	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	926,038	53,214	979,252	0	979,252	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	0	14.00
15.00	01500	PHARMACY	1,296,703	2,320,182	3,616,885	0	3,616,885	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	115,589	240,682	356,271	0	356,271	0	16.00
17.00	01700	SOCIAL SERVICE	118,299	1,400	119,699	0	119,699	0	17.00
17.01	01702	PASTORAL CARE	45,035	378	45,413	0	45,413	0	17.01
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0	0	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>									
30.00	03000	ADULTS & PEDIATRICS	7,014,969	2,015,672	9,030,641	0	9,030,641	0	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>									
50.00	05000	OPERATING ROOM	146,365	287,427	433,792	0	433,792	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	179,250	131,284	310,534	0	310,534	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	0	56.00
57.00	05700	CT SCAN	150,360	2,317	152,677	0	152,677	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	659,380	659,380	0	659,380	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	0	60.01
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	0	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	0	62.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	125,329	125,329	0	125,329	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	2,011,896	1,801,963	3,813,859	0	3,813,859	0	65.00
66.00	06600	PHYSICAL THERAPY	460,168	42,758	502,926	0	502,926	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	243,848	3,531	247,379	0	247,379	0	67.00
68.00	06800	SPEECH PATHOLOGY	150,316	8,223	158,539	0	158,539	0	68.00
69.00	06900	ELECTROCARDIOLOGY	157,792	1,367	159,159	0	159,159	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,521	168	1,689	0	1,689	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	560,876	560,876	0	560,876	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	0	75.00
<b>SPECIAL PURPOSE COST CENTERS</b>									
118.00		SUBTOTALS (SUM OF LINES 1-117)	16,889,504	20,021,766	36,911,270	0	36,911,270	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>									
193.00	19300	NONPAID WORKERS	0	0	0	0	0	0	193.00
193.01	19302	MARKETING	0	0	0	0	0	0	193.01
193.02	19301	VACANT SPACE	0	0	0	0	0	0	193.02
200.00		TOTAL (SUM OF LINES 118-199)	16,889,504	20,021,766	36,911,270	0	36,911,270	0	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 152020

Period:  
From 07/01/2013  
To 06/30/2014

Worksheet A  
Date/Time Prepared:  
11/19/2014 12:21 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-12,248	962,056	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	1,147,419	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	125,066	6,277,899	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,146,330	6,447,968	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700	OPERATION OF PLANT	-2,075	1,810,844	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	136,221	8.00
9.00	00900	HOUSEKEEPING	0	405,523	9.00
10.00	01000	DIETARY	-84,752	621,361	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	-22,534	956,718	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	14.00
15.00	01500	PHARMACY	-1,958	3,614,927	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-7,016	349,255	16.00
17.00	01700	SOCIAL SERVICE	0	119,699	17.00
17.01	01702	PASTORAL CARE	0	45,413	17.01
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	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
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	0	9,030,641	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0	433,792	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	310,534	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	152,677	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	659,380	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	125,329	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	3,813,859	65.00
66.00	06600	PHYSICAL THERAPY	0	502,926	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	247,379	67.00
68.00	06800	SPEECH PATHOLOGY	0	158,539	68.00
69.00	06900	ELECTROCARDIOLOGY	0	159,159	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,689	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	560,876	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	75.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,140,813	39,052,083	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
193.00	19300	NONPAID WORKERS	0	0	193.00
193.01	19302	MARKETING	188,678	188,678	193.01
193.02	19301	VACANT SPACE	0	0	193.02
200.00		TOTAL (SUM OF LINES 118-199)	2,329,491	39,240,761	200.00

RECLASSIFICATIONS

Provider CCN: 152020

Period:  
From 07/01/2013  
To 06/30/2014

Worksheet A-6

Date/Time Prepared:  
11/19/2014 12:21 pm

		Increases				
Cost Center		Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
A - INTEREST						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,351	1.00	
	TOTALS		0	1,351		
500.00	Grand Total: Increases		0	1,351	500.00	

RECLASSIFICATIONS

Provider CCN: 152020

Period:  
From 07/01/2013  
To 06/30/2014

Worksheet A-6

Date/Time Prepared:  
11/19/2014 12:21 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	1,351	9	1.00	
	TOTALS		0	1,351			
500.00	Grand Total: Decreases		0	1,351		500.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 152020

Period:  
From 07/01/2013  
To 06/30/2014

Worksheet A-7  
Part I  
Date/Time Prepared:  
11/19/2014 12:21 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	847,629	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	21,290,469	680,257	0	680,257	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	0	0	0	0	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	22,138,098	680,257	0	680,257	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	22,138,098	680,257	0	680,257	0	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	847,629	0				1.00
2.00	Land Improvements	0	0				2.00
3.00	Buildings and Fixtures	21,970,726	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	0	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	22,818,355	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	22,818,355	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 152020

Period:  
From 07/01/2013  
To 06/30/2014

Worksheet A-7  
Part II  
Date/Time Prepared:  
11/19/2014 12:21 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	814,464	134,371	13,599	12,676	545	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	269,668	876,251	0	1,500	0	2.00
3.00	Total (sum of lines 1-2)	1,084,132	1,010,622	13,599	14,176	545	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	975,655				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,147,419				2.00
3.00	Total (sum of lines 1-2)	0	2,123,074				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 152020

Period:  
From 07/01/2013  
To 06/30/2014

Worksheet A-7  
Part III  
Date/Time Prepared:  
11/19/2014 12:21 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	17,013,132	0	17,013,132	0.774355	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	4,957,594	0	4,957,594	0.225645	0	2.00
3.00	Total (sum of lines 1-2)	21,970,726	0	21,970,726	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	805,700	134,371	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	269,668	876,251	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,075,368	1,010,622	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	8,764	12,676	545	0	962,056	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,500	0	0	1,147,419	2.00
3.00	Total (sum of lines 1-2)	8,764	14,176	545	0	2,109,475	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 152020

Period:  
From 07/01/2013  
To 06/30/2014

Worksheet A-8

Date/Time Prepared:  
11/19/2014 12:21 pm

Line #	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.
				Cost Center	Line #		
				1.00	2.00	3.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-7,413	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	-818	ADMINISTRATIVE & GENERAL	5.00		0 3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00		0 4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00		0 5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00		0 6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00		0 7.00
8.00	Television and radio service (chapter 21)		0		0.00		0 8.00
9.00	Parking lot (chapter 21)		0		0.00		0 9.00
10.00	Provider-based physician adjustment	A-8-2	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	2,458,373				0 12.00
13.00	Laundry and linen service		0		0.00		0 13.00
14.00	Cafeteria-employees and guests	B	-84,752	DIETARY	10.00		0 14.00
15.00	Rental of quarters to employee and others		0		0.00		0 15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00		0 16.00
17.00	Sale of drugs to other than patients		0		0.00		0 17.00
18.00	Sale of medical records and abstracts		0		0.00		0 18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00		0 19.00
20.00	Vending machines		0		0.00		0 20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00		0 21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00		0 22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00		0 26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00		0 27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00		0 29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00		0 32.00
33.00	MEDICAL RECORDS INCOME	B	-7,016	MEDICAL RECORDS & LIBRARY	16.00		0 33.00
33.01	NURSING ADMIN MISC INCOME	B	-21,750	NURSING ADMINISTRATION	13.00		0 33.01

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Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
			Cost Center	Line #		
			1.00	2.00		
33.02 LOBBYING - NALTH	A	-2,376	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03 LOBBYING - HOME OFFICE	A	-928	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04 CHARITABLE EXPENSES	A	-1,958	PHARMACY	15.00	0	33.04
33.05 CHARITABLE EXPENSES	A	-1,087	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06 CHARITABLE EXPENSES	A	-784	NURSING ADMINISTRATION	13.00	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
33.14		0		0.00	0	33.14
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		2,329,491				50.00

- (1) Description - all chapter references in this column pertain to CMS Pub. 15-1.  
 (2) Basis for adjustment (see instructions).  
     A. Costs - if cost, including applicable overhead, can be determined.  
     B. Amount Received - if cost cannot be determined.  
 (3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.  
 Note: See instructions for column 5 referencing to Worksheet A-7.

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

Provider CCN: 152020

Period: From 07/01/2013 To 06/30/2014

Worksheet A-8-1

Date/Time Prepared: 11/19/2014 12:21 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	
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>					
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT HOME OFFICE	0	145,534	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL HOME OFFICE	3,900,682	1,748,610	2.00
3.00	193.01	MARKETING HOME OFFICE	188,678	0	3.00
4.00	4.00	EMPLOYEE BENEFITS DEPARTMENT SVH CHARGEBACK	268,953	268,953	4.00
4.01	5.00	ADMINISTRATIVE & GENERAL SVH CHARGEBACK	247,129	247,129	4.01
4.02	7.00	OPERATION OF PLANT SVH CHARGEBACK	103,159	103,159	4.02
4.03	13.00	NURSING ADMINISTRATION SVH CHARGEBACK	3,000	3,000	4.03
4.04	15.00	PHARMACY SVH CHARGEBACK	21,552	21,552	4.04
4.05	16.00	MEDICAL RECORDS & LIBRARY SVH CHARGEBACK	101,856	101,856	4.05
4.06	17.01	PASTORAL CARE SVH CHARGEBACK	45,035	45,035	4.06
4.07	54.00	RADIOLOGY-DIAGNOSTIC SVH CHARGEBACK	182,412	182,412	4.07
4.08	57.00	CT SCAN SVH CHARGEBACK	150,360	150,360	4.08
4.09	4.00	EMPLOYEE BENEFITS DEPARTMENT SELF INSURANCE	2,468,325	2,525,562	4.09
4.10	1.00	CAP REL COSTS-BLDG & FIXT ASCENSION INTEREST	7,413	12,248	4.10
4.11	5.00	ADMINISTRATIVE & GENERAL ASCENSION INTEREST	818	1,351	4.11
4.12	7.00	OPERATION OF PLANT TRIMEDX	319,624	321,699	4.12
4.13	4.00	EMPLOYEE BENEFITS DEPARTMENT PENSION	688,197	360,360	4.13
4.14	0.00		0	0	4.14
4.15	0.00		0	0	4.15
4.16	0.00		0	0	4.16
4.17	0.00		0	0	4.17
4.18	0.00		0	0	4.18
4.19	0.00		0	0	4.19
4.20	0.00		0	0	4.20
4.21	0.00		0	0	4.21
4.22	0.00		0	0	4.22
4.23	0.00		0	0	4.23
4.24	0.00		0	0	4.24
4.25	0.00		0	0	4.25
4.26	0.00		0	0	4.26
4.27	0.00		0	0	4.27
4.28	0.00		0	0	4.28
4.29	0.00		0	0	4.29
4.30	0.00		0	0	4.30
4.31	0.00		0	0	4.31
4.32	0.00		0	0	4.32
4.33	0.00		0	0	4.33
4.34	0.00		0	0	4.34
4.35	0.00		0	0	4.35
5.00	0		8,697,193	6,238,820	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 HEAL	100.00	ST VINCENT HEAL	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
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

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

Provider CCN: 152020

Period:  
From 07/01/2013  
To 06/30/2014

Worksheet A-8-1

Date/Time Prepared:  
11/19/2014 12:21 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

(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: 152020

Period:  
From 07/01/2013  
To 06/30/2014

Worksheet A-8-1

Date/Time Prepared:  
11/19/2014 12:21 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>				
1.00	-145,534	0		1.00
2.00	2,152,072	0		2.00
3.00	188,678	0		3.00
4.00	0	0		4.00
4.01	0	0		4.01
4.02	0	0		4.02
4.03	0	0		4.03
4.04	0	0		4.04
4.05	0	0		4.05
4.06	0	0		4.06
4.07	0	0		4.07
4.08	0	0		4.08
4.09	-57,237	0		4.09
4.10	-4,835	11		4.10
4.11	-533	0		4.11
4.12	-2,075	0		4.12
4.13	327,837	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	0	0		4.22
4.23	0	9		4.23
4.24	0	0		4.24
4.25	0	0		4.25
4.26	0	0		4.26
4.27	0	0		4.27
4.28	0	11		4.28
4.29	0	0		4.29
4.30	0	0		4.30
4.31	0	0		4.31
4.32	0	12		4.32
4.33	0	12		4.33
4.34	0	0		4.34
4.35	0	0		4.35
5.00	2,458,373			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: 152020

Period:  
From 07/01/2013  
To 06/30/2014

Worksheet A-8-1

Date/Time Prepared:  
11/19/2014 12:21 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 ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 152020

Period:  
From 07/01/2013  
To 06/30/2014

Worksheet B  
Part I  
Date/Time Prepared:  
11/19/2014 12:21 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	962,056	962,056			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	1,147,419		1,147,419		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	6,277,899	0	0	6,277,899	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	6,447,968	45,221	53,933	946,789	7,493,911 5.00
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	0 6.00
7.00 00700	OPERATION OF PLANT	1,810,844	48,206	57,493	141,615	2,058,158 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	136,221	7,869	9,386	0	153,476 8.00
9.00 00900	HOUSEKEEPING	405,523	10,932	13,038	0	429,493 9.00
10.00 01000	DIETARY	621,361	39,018	46,536	0	706,915 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	956,718	63,499	75,733	369,151	1,465,101 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0 14.00
15.00 01500	PHARMACY	3,614,927	22,911	27,325	516,911	4,182,074 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	349,255	10,409	12,414	46,078	418,156 16.00
17.00 01700	SOCIAL SERVICE	119,699	5,718	6,820	47,158	179,395 17.00
17.01 01702	PASTORAL CARE	45,413	7,055	8,415	17,953	78,836 17.01
18.00 01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0 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
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	9,030,641	650,513	775,849	2,796,419	13,253,422 30.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	433,792	6,900	8,230	58,346	507,268 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	310,534	12,405	14,795	71,455	409,189 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	152,677	3,295	3,930	59,939	219,841 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	659,380	2,694	3,213	0	665,287 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.	125,329	0	0	0	125,329 63.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0 64.00
65.00 06500	RESPIRATORY THERAPY	3,813,859	4,885	5,826	802,012	4,626,582 65.00
66.00 06600	PHYSICAL THERAPY	502,926	6,842	8,161	183,439	701,368 66.00
67.00 06700	OCCUPATIONAL THERAPY	247,379	6,842	8,161	97,206	359,588 67.00
68.00 06800	SPEECH PATHOLOGY	158,539	6,842	8,161	59,921	233,463 68.00
69.00 06900	ELECTROCARDIOLOGY	159,159	0	0	62,901	222,060 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	1,689	0	0	606	2,295 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	560,876	0	0	0	560,876 74.00
75.00 07500	ASC (NON-DISTINCT PART)	0	0	0	0	0 75.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1-117)	39,052,083	962,056	1,147,419	6,277,899	39,052,083 118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
193.00 19300	NONPAID WORKERS	0	0	0	0	0 193.00
193.01 19302	MARKETING	188,678	0	0	0	188,678 193.01
193.02 19301	VACANT SPACE	0	0	0	0	0 193.02
200.00	Cross Foot Adjustments					0 200.00
201.00	Negative Cost Centers					0 201.00
202.00	TOTAL (sum lines 118-201)	39,240,761	962,056	1,147,419	6,277,899	39,240,761 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 152020

Period:  
From 07/01/2013  
To 06/30/2014

Worksheet B  
Part I  
Date/Time Prepared:  
11/19/2014 12:21 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	
<b>GENERAL SERVICE COST CENTERS</b>								
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	7,493,911					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	485,832	0	2,543,990			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	36,228	0	23,048	212,752		8.00
9.00	00900	HOUSEKEEPING	101,383	0	32,017	0	562,893	9.00
10.00	01000	DIETARY	166,869	0	114,273	0	25,844	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	345,840	0	185,971	0	42,059	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	987,187	0	67,099	0	15,175	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	98,707	0	30,484	0	6,894	16.00
17.00	01700	SOCIAL SERVICE	42,347	0	16,746	0	3,787	17.00
17.01	01702	PASTORAL CARE	18,609	0	20,663	0	4,673	17.01
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0	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 PRGM-(SPECIFY)	0	0	0	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	3,128,500	0	1,905,185	212,752	430,874	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	119,742	0	20,209	0	4,571	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	96,590	0	36,331	0	8,217	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	51,894	0	9,651	0	2,183	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	157,042	0	7,891	0	1,785	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.	29,584	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,092,114	0	14,305	0	3,235	65.00
66.00	06600	PHYSICAL THERAPY	165,559	0	20,039	0	4,532	66.00
67.00	06700	OCCUPATIONAL THERAPY	84,881	0	20,039	0	4,532	67.00
68.00	06800	SPEECH PATHOLOGY	55,109	0	20,039	0	4,532	68.00
69.00	06900	ELECTROCARDIOLOGY	52,418	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	542	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	132,396	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
118.00		SUBTOTALS (SUM OF LINES 1-117)	7,449,373	0	2,543,990	212,752	562,893	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19302	MARKETING	44,538	0	0	0	0	193.01
193.02	19301	VACANT SPACE	0	0	0	0	0	193.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	7,493,911	0	2,543,990	212,752	562,893	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 152020

Period:  
From 07/01/2013  
To 06/30/2014

Worksheet B  
Part I  
Date/Time Prepared:  
11/19/2014 12:21 pm

Cost Center Description		DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
		10.00	11.00	12.00	13.00	14.00	
<b>GENERAL SERVICE COST CENTERS</b>							
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	1,013,901					10.00
11.00	01100	0	0				11.00
12.00	01200	0	0	0			12.00
13.00	01300	0	0	0	2,038,971		13.00
14.00	01400	0	0	0	0	0	14.00
15.00	01500	0	0	0	0	0	15.00
16.00	01600	0	0	0	0	0	16.00
17.00	01700	0	0	0	0	0	17.00
17.01	01702	0	0	0	0	0	17.01
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
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	1,013,901	0	0	1,489,954	0	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
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	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	387,901	0	65.00
66.00	06600	0	0	0	90,438	0	66.00
67.00	06700	0	0	0	45,941	0	67.00
68.00	06800	0	0	0	24,737	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
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		1,013,901	0	0	2,038,971	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
193.00	19300	0	0	0	0	0	193.00
193.01	19302	0	0	0	0	0	193.01
193.02	19301	0	0	0	0	0	193.02
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		1,013,901	0	0	2,038,971	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 152020

Period:  
From 07/01/2013  
To 06/30/2014

Worksheet B  
Part I  
Date/Time Prepared:  
11/19/2014 12:21 pm

Cost Center Description		PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	PASTORAL CARE	OTHER GENERAL SERVICE (SPECIFY)	
		15.00	16.00	17.00	17.01	18.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
12.00	01200						12.00
13.00	01300						13.00
14.00	01400						14.00
15.00	01500	5,251,535					15.00
16.00	01600		554,241				16.00
17.00	01700			242,275			17.00
17.01	01702				122,781		17.01
18.00	01850						18.00
19.00	01900						19.00
20.00	02000						20.00
21.00	02100						21.00
22.00	02200						22.00
23.00	02300						23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000		201,214	242,275	122,781		30.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000		15,935				50.00
51.00	05100						51.00
52.00	05200						52.00
53.00	05300						53.00
54.00	05400		10,060				54.00
55.00	05500						55.00
56.00	05600						56.00
57.00	05700		2,470				57.00
58.00	05800						58.00
59.00	05900						59.00
60.00	06000		50,636				60.00
60.01	06001						60.01
61.00	06100						61.00
62.00	06200						62.00
63.00	06300		3,911				63.00
64.00	06400						64.00
65.00	06500		141,780				65.00
66.00	06600		12,861				66.00
67.00	06700		10,899				67.00
68.00	06800		4,442				68.00
69.00	06900		1,371				69.00
70.00	07000		162				70.00
71.00	07100						71.00
72.00	07200						72.00
73.00	07300	5,251,535	89,547				73.00
74.00	07400		8,953				74.00
75.00	07500						75.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		5,251,535	554,241	242,275	122,781		118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
193.00	19300						193.00
193.01	19302						193.01
193.02	19301						193.02
200.00							200.00
201.00							201.00
202.00		5,251,535	554,241	242,275	122,781		202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 152020

Period:  
From 07/01/2013  
To 06/30/2014

Worksheet B  
Part I  
Date/Time Prepared:  
11/19/2014 12:21 pm

Cost Center Description	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	INTERNS & RESIDENTS		PARAMED PRGM	
			SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS		
			19.00	20.00		
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00 00500	ADMINISTRATIVE & GENERAL					5.00
6.00 00600	MAINTENANCE & REPAIRS					6.00
7.00 00700	OPERATION OF PLANT					7.00
8.00 00800	LAUNDRY & LINEN SERVICE					8.00
9.00 00900	HOUSEKEEPING					9.00
10.00 01000	DIETARY					10.00
11.00 01100	CAFETERIA					11.00
12.00 01200	MAINTENANCE OF PERSONNEL					12.00
13.00 01300	NURSING ADMINISTRATION					13.00
14.00 01400	CENTRAL SERVICES & SUPPLY					14.00
15.00 01500	PHARMACY					15.00
16.00 01600	MEDICAL RECORDS & LIBRARY					16.00
17.00 01700	SOCIAL SERVICE					17.00
17.01 01702	PASTORAL CARE					17.01
18.00 01850	OTHER GENERAL SERVICE (SPECIFY)					18.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0				19.00
20.00 02000	NURSING SCHOOL	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	0	0	22.00
23.00 02300	PARAMED PRGM-(SPECIFY)	0	0	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	0	0	0	0	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
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
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	0	0	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
193.00 19300	NONPAID WORKERS	0	0	0	0	193.00
193.01 19302	MARKETING	0	0	0	0	193.01
193.02 19301	VACANT SPACE	0	0	0	0	193.02
200.00	Cross Foot Adjustments	0	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	0	0	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 152020

Period:  
From 07/01/2013  
To 06/30/2014

Worksheet B  
Part I  
Date/Time Prepared:  
11/19/2014 12:21 pm

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100				1.00
2.00	00200				2.00
4.00	00400				4.00
5.00	00500				5.00
6.00	00600				6.00
7.00	00700				7.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
12.00	01200				12.00
13.00	01300				13.00
14.00	01400				14.00
15.00	01500				15.00
16.00	01600				16.00
17.00	01700				17.00
17.01	01702				17.01
18.00	01850				18.00
19.00	01900				19.00
20.00	02000				20.00
21.00	02100				21.00
22.00	02200				22.00
23.00	02300				23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	22,000,858	0	22,000,858	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	667,725	0	667,725	50.00
51.00	05100	0	0	0	51.00
52.00	05200	0	0	0	52.00
53.00	05300	0	0	0	53.00
54.00	05400	560,387	0	560,387	54.00
55.00	05500	0	0	0	55.00
56.00	05600	0	0	0	56.00
57.00	05700	286,039	0	286,039	57.00
58.00	05800	0	0	0	58.00
59.00	05900	0	0	0	59.00
60.00	06000	882,641	0	882,641	60.00
60.01	06001	0	0	0	60.01
61.00	06100	0	0	0	61.00
62.00	06200	0	0	0	62.00
63.00	06300	158,824	0	158,824	63.00
64.00	06400	0	0	0	64.00
65.00	06500	6,265,917	0	6,265,917	65.00
66.00	06600	994,797	0	994,797	66.00
67.00	06700	525,880	0	525,880	67.00
68.00	06800	342,322	0	342,322	68.00
69.00	06900	275,849	0	275,849	69.00
70.00	07000	2,999	0	2,999	70.00
71.00	07100	0	0	0	71.00
72.00	07200	0	0	0	72.00
73.00	07300	5,341,082	0	5,341,082	73.00
74.00	07400	702,225	0	702,225	74.00
75.00	07500	0	0	0	75.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
118.00		39,007,545	0	39,007,545	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
193.00	19300	0	0	0	193.00
193.01	19302	233,216	0	233,216	193.01
193.02	19301	0	0	0	193.02
200.00		0	0	0	200.00
201.00		0	0	0	201.00
202.00		39,240,761	0	39,240,761	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 152020	Period: From 07/01/2013 To 06/30/2014	Worksheet B Part II Date/Time Prepared: 11/19/2014 12:21 pm
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
<b>GENERAL SERVICE COST CENTERS</b>						
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	632,023	45,221	53,933	731,177	5.00
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00 00700	OPERATION OF PLANT	0	48,206	57,493	105,699	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	7,869	9,386	17,255	8.00
9.00 00900	HOUSEKEEPING	0	10,932	13,038	23,970	9.00
10.00 01000	DIETARY	0	39,018	46,536	85,554	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	63,499	75,733	139,232	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00 01500	PHARMACY	0	22,911	27,325	50,236	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	10,409	12,414	22,823	16.00
17.00 01700	SOCIAL SERVICE	0	5,718	6,820	12,538	17.00
17.01 01702	PASTORAL CARE	0	7,055	8,415	15,470	17.01
18.00 01850	OTHER GENERAL SERVICE (SPECIFY)	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 PRGM-(SPECIFY)	0	0	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	0	650,513	775,849	1,426,362	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	0	6,900	8,230	15,130	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	12,405	14,795	27,200	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	3,295	3,930	7,225	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	2,694	3,213	5,907	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	4,885	5,826	10,711	65.00
66.00 06600	PHYSICAL THERAPY	0	6,842	8,161	15,003	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	6,842	8,161	15,003	67.00
68.00 06800	SPEECH PATHOLOGY	0	6,842	8,161	15,003	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
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1-117)	632,023	962,056	1,147,419	2,741,498	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
193.00 19300	NONPAID WORKERS	0	0	0	0	193.00
193.01 19302	MARKETING	0	0	0	0	193.01
193.02 19301	VACANT SPACE	0	0	0	0	193.02
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	632,023	962,056	1,147,419	2,741,498	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 152020	Period: From 07/01/2013 To 06/30/2014	Worksheet B Part II Date/Time Prepared: 11/19/2014 12:21 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		
<b>GENERAL SERVICE COST CENTERS</b>								
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	731,177			5.00		
6.00	00600	MAINTENANCE & REPAIRS	0	0		6.00		
7.00	00700	OPERATION OF PLANT	47,401	0	153,100	7.00		
8.00	00800	LAUNDRY & LINEN SERVICE	3,535	0	1,387	22,177	8.00	
9.00	00900	HOUSEKEEPING	9,892	0	1,927	0	35,789	9.00
10.00	01000	DIETARY	16,281	0	6,877	0	1,643	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	33,743	0	11,192	0	2,674	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	96,317	0	4,038	0	965	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,631	0	1,835	0	438	16.00
17.00	01700	SOCIAL SERVICE	4,132	0	1,008	0	241	17.00
17.01	01702	PASTORAL CARE	1,816	0	1,244	0	297	17.01
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0	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 PRGM-(SPECIFY)	0	0	0	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	305,254	0	114,655	22,177	27,396	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	11,683	0	1,216	0	291	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	9,424	0	2,186	0	522	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	5,063	0	581	0	139	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	15,322	0	475	0	113	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.	2,886	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	106,555	0	861	0	206	65.00
66.00	06600	PHYSICAL THERAPY	16,153	0	1,206	0	288	66.00
67.00	06700	OCCUPATIONAL THERAPY	8,282	0	1,206	0	288	67.00
68.00	06800	SPEECH PATHOLOGY	5,377	0	1,206	0	288	68.00
69.00	06900	ELECTROCARDIOLOGY	5,114	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	53	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	12,918	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
118.00		SUBTOTALS (SUM OF LINES 1-117)	726,832	0	153,100	22,177	35,789	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19302	MARKETING	4,345	0	0	0	0	193.01
193.02	19301	VACANT SPACE	0	0	0	0	0	193.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	731,177	0	153,100	22,177	35,789	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 152020

Period:  
From 07/01/2013  
To 06/30/2014

Worksheet B  
Part II  
Date/Time Prepared:  
11/19/2014 12:21 pm

Cost Center Description		DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
		10.00	11.00	12.00	13.00	14.00	
<b>GENERAL SERVICE COST CENTERS</b>							
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	110,355					10.00
11.00	01100	0	0				11.00
12.00	01200	0	0	0			12.00
13.00	01300	0	0	0	186,841		13.00
14.00	01400	0	0	0	0	0	14.00
15.00	01500	0	0	0	0	0	15.00
16.00	01600	0	0	0	0	0	16.00
17.00	01700	0	0	0	0	0	17.00
17.01	01702	0	0	0	0	0	17.01
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
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	110,355	0	0	136,532	0	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
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	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	35,545	0	65.00
66.00	06600	0	0	0	8,287	0	66.00
67.00	06700	0	0	0	4,210	0	67.00
68.00	06800	0	0	0	2,267	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
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		110,355	0	0	186,841	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
193.00	19300	0	0	0	0	0	193.00
193.01	19302	0	0	0	0	0	193.01
193.02	19301	0	0	0	0	0	193.02
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		110,355	0	0	186,841	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 152020

Period:  
From 07/01/2013  
To 06/30/2014

Worksheet B  
Part II  
Date/Time Prepared:  
11/19/2014 12:21 pm

Cost Center Description		PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	PASTORAL CARE	OTHER GENERAL SERVICE (SPECIFY)	
		15.00	16.00	17.00	17.01	18.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
12.00	01200						12.00
13.00	01300						13.00
14.00	01400						14.00
15.00	01500	151,556					15.00
16.00	01600	0	34,727				16.00
17.00	01700	0	0	17,919			17.00
17.01	01702	0	0	0	18,827		17.01
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
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	0	12,572	17,919	18,827	0	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	0	1,000	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	631	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	155	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	3,178	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	245	0	0	0	63.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	0	8,898	0	0	0	65.00
66.00	06600	0	807	0	0	0	66.00
67.00	06700	0	684	0	0	0	67.00
68.00	06800	0	279	0	0	0	68.00
69.00	06900	0	86	0	0	0	69.00
70.00	07000	0	10	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	151,556	5,620	0	0	0	73.00
74.00	07400	0	562	0	0	0	74.00
75.00	07500	0	0	0	0	0	75.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		151,556	34,727	17,919	18,827	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
193.00	19300	0	0	0	0	0	193.00
193.01	19302	0	0	0	0	0	193.01
193.02	19301	0	0	0	0	0	193.02
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		151,556	34,727	17,919	18,827	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 152020

Period:  
From 07/01/2013  
To 06/30/2014

Worksheet B  
Part II  
Date/Time Prepared:  
11/19/2014 12:21 pm

Cost Center Description	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	INTERNS & RESIDENTS		PARAMED PRGM	
			SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS		
			19.00	20.00		
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00 00500	ADMINISTRATIVE & GENERAL					5.00
6.00 00600	MAINTENANCE & REPAIRS					6.00
7.00 00700	OPERATION OF PLANT					7.00
8.00 00800	LAUNDRY & LINEN SERVICE					8.00
9.00 00900	HOUSEKEEPING					9.00
10.00 01000	DIETARY					10.00
11.00 01100	CAFETERIA					11.00
12.00 01200	MAINTENANCE OF PERSONNEL					12.00
13.00 01300	NURSING ADMINISTRATION					13.00
14.00 01400	CENTRAL SERVICES & SUPPLY					14.00
15.00 01500	PHARMACY					15.00
16.00 01600	MEDICAL RECORDS & LIBRARY					16.00
17.00 01700	SOCIAL SERVICE					17.00
17.01 01702	PASTORAL CARE					17.01
18.00 01850	OTHER GENERAL SERVICE (SPECIFY)					18.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0				19.00
20.00 02000	NURSING SCHOOL		0			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 PRGM-(SPECIFY)					0 23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS					30.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM					50.00
51.00 05100	RECOVERY ROOM					51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM					52.00
53.00 05300	ANESTHESIOLOGY					53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC					54.00
55.00 05500	RADIOLOGY-THERAPEUTIC					55.00
56.00 05600	RADIOISOTOPE					56.00
57.00 05700	CT SCAN					57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)					58.00
59.00 05900	CARDIAC CATHETERIZATION					59.00
60.00 06000	LABORATORY					60.00
60.01 06001	BLOOD LABORATORY					60.01
61.00 06100	PBP CLINICAL LAB SERVICES-PRGM ONLY					61.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS					62.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.					63.00
64.00 06400	INTRAVENOUS THERAPY					64.00
65.00 06500	RESPIRATORY THERAPY					65.00
66.00 06600	PHYSICAL THERAPY					66.00
67.00 06700	OCCUPATIONAL THERAPY					67.00
68.00 06800	SPEECH PATHOLOGY					68.00
69.00 06900	ELECTROCARDIOLOGY					69.00
70.00 07000	ELECTROENCEPHALOGRAPHY					70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS					71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS					72.00
73.00 07300	DRUGS CHARGED TO PATIENTS					73.00
74.00 07400	RENAL DIALYSIS					74.00
75.00 07500	ASC (NON-DISTINCT PART)					75.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	0	0	0	0 118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
193.00 19300	NONPAID WORKERS					193.00
193.01 19302	MARKETING					193.01
193.02 19301	VACANT SPACE					193.02
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)	0	0	0	0	0 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 152020

Period:  
From 07/01/2013  
To 06/30/2014

Worksheet B  
Part II  
Date/Time Prepared:  
11/19/2014 12:21 pm

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100				1.00
2.00	00200				2.00
4.00	00400				4.00
5.00	00500				5.00
6.00	00600				6.00
7.00	00700				7.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
12.00	01200				12.00
13.00	01300				13.00
14.00	01400				14.00
15.00	01500				15.00
16.00	01600				16.00
17.00	01700				17.00
17.01	01702				17.01
18.00	01850				18.00
19.00	01900				19.00
20.00	02000				20.00
21.00	02100				21.00
22.00	02200				22.00
23.00	02300				23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	2,192,049	0	2,192,049	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	29,320	0	29,320	50.00
51.00	05100	0	0	0	51.00
52.00	05200	0	0	0	52.00
53.00	05300	0	0	0	53.00
54.00	05400	39,963	0	39,963	54.00
55.00	05500	0	0	0	55.00
56.00	05600	0	0	0	56.00
57.00	05700	13,163	0	13,163	57.00
58.00	05800	0	0	0	58.00
59.00	05900	0	0	0	59.00
60.00	06000	24,995	0	24,995	60.00
60.01	06001	0	0	0	60.01
61.00	06100	0	0	0	61.00
62.00	06200	0	0	0	62.00
63.00	06300	3,131	0	3,131	63.00
64.00	06400	0	0	0	64.00
65.00	06500	162,776	0	162,776	65.00
66.00	06600	41,744	0	41,744	66.00
67.00	06700	29,673	0	29,673	67.00
68.00	06800	24,420	0	24,420	68.00
69.00	06900	5,200	0	5,200	69.00
70.00	07000	63	0	63	70.00
71.00	07100	0	0	0	71.00
72.00	07200	0	0	0	72.00
73.00	07300	157,176	0	157,176	73.00
74.00	07400	13,480	0	13,480	74.00
75.00	07500	0	0	0	75.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
118.00		2,737,153	0	2,737,153	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
193.00	19300	0	0	0	193.00
193.01	19302	4,345	0	4,345	193.01
193.02	19301	0	0	0	193.02
200.00		0	0	0	200.00
201.00		0	0	0	201.00
202.00		2,741,498	0	2,741,498	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 152020

Period:  
From 07/01/2013  
To 06/30/2014

Worksheet B-1  
Date/Time Prepared:  
11/19/2014 12:21 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	49,634				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		49,634			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	15,748,477		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	2,333	2,333	2,375,078	-7,493,911	31,746,850
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	0
7.00 00700	OPERATION OF PLANT	2,487	2,487	355,250	0	2,058,158
8.00 00800	LAUNDRY & LINEN SERVICE	406	406	0	0	153,476
9.00 00900	HOUSEKEEPING	564	564	0	0	429,493
10.00 01000	DIETARY	2,013	2,013	0	0	706,915
11.00 01100	CAFETERIA	0	0	0	0	0
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00 01300	NURSING ADMINISTRATION	3,276	3,276	926,038	0	1,465,101
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0
15.00 01500	PHARMACY	1,182	1,182	1,296,703	0	4,182,074
16.00 01600	MEDICAL RECORDS & LIBRARY	537	537	115,589	0	418,156
17.00 01700	SOCIAL SERVICE	295	295	118,299	0	179,395
17.01 01702	PASTORAL CARE	364	364	45,035	0	78,836
18.00 01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
20.00 02000	NURSING SCHOOL	0	0	0	0	0
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0
23.00 02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	33,561	33,561	7,014,969	0	13,253,422
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	356	356	146,365	0	507,268
51.00 05100	RECOVERY ROOM	0	0	0	0	0
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0
53.00 05300	ANESTHESIOLOGY	0	0	0	0	0
54.00 05400	RADIOLOGY-DIAGNOSTIC	640	640	179,250	0	409,189
55.00 05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0
56.00 05600	RADIOISOTOPE	0	0	0	0	0
57.00 05700	CT SCAN	170	170	150,360	0	219,841
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00 06000	LABORATORY	139	139	0	0	665,287
60.01 06001	BLOOD LABORATORY	0	0	0	0	0
61.00 06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	125,329
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00 06500	RESPIRATORY THERAPY	252	252	2,011,896	0	4,626,582
66.00 06600	PHYSICAL THERAPY	353	353	460,168	0	701,368
67.00 06700	OCCUPATIONAL THERAPY	353	353	243,848	0	359,588
68.00 06800	SPEECH PATHOLOGY	353	353	150,316	0	233,463
69.00 06900	ELECTROCARDIOLOGY	0	0	157,792	0	222,060
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	1,521	0	2,295
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
74.00 07400	RENAL DIALYSIS	0	0	0	0	560,876
75.00 07500	ASC (NON-DISTINCT PART)	0	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1-117)	49,634	49,634	15,748,477	-7,493,911	31,558,172
<b>NONREIMBURSABLE COST CENTERS</b>						
193.00 19300	NONPAID WORKERS	0	0	0	0	0
193.01 19302	MARKETING	0	0	0	0	188,678
193.02 19301	VACANT SPACE	0	0	0	0	0
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	962,056	1,147,419	6,277,899		7,493,911
203.00	Unit cost multiplier (Wkst. B, Part I)	19.383004	23.117601	0.398635		0.236052
204.00	Cost to be allocated (per Wkst. B, Part II)			0		731,177
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000000		0.023031

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 152020

Period:  
From 07/01/2013  
To 06/30/2014

Worksheet B-1

Date/Time Prepared:  
11/19/2014 12:21 pm

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (TOTAL PATIENT DAYS)	
		6.00	7.00	8.00	9.00	10.00	
<b>GENERAL SERVICE COST CENTERS</b>							
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		44,814				7.00
8.00	00800		406	100			8.00
9.00	00900	0	564		43,844		9.00
10.00	01000	0	2,013	0	2,013	22,113	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	3,276	0	3,276	0	13.00
14.00	01400	0	0	0	0	0	14.00
15.00	01500	0	1,182	0	1,182	0	15.00
16.00	01600	0	537	0	537	0	16.00
17.00	01700	0	295	0	295	0	17.00
17.01	01702	0	364	0	364	0	17.01
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
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	0	33,561	100	33,561	22,113	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	0	356	0	356	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	640	0	640	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	170	0	170	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	139	0	139	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	252	0	252	0	65.00
66.00	06600	0	353	0	353	0	66.00
67.00	06700	0	353	0	353	0	67.00
68.00	06800	0	353	0	353	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
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		0	44,814	100	43,844	22,113	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
193.00	19300	0	0	0	0	0	193.00
193.01	19302	0	0	0	0	0	193.01
193.02	19301	0	0	0	0	0	193.02
200.00							200.00
201.00							201.00
202.00		0	2,543,990	212,752	562,893	1,013,901	202.00
203.00		0.000000	56.767751	2,127.520000	12.838541	45.850902	203.00
204.00		0	153,100	22,177	35,789	110,355	204.00
205.00		0.000000	3.416343	221.770000	0.816280	4.990503	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 152020

Period:  
From 07/01/2013  
To 06/30/2014

Worksheet B-1

Date/Time Prepared:  
11/19/2014 12:21 pm

Cost Center Description		CAFETERIA (MEALS SERVED)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
		11.00	12.00	13.00	14.00	15.00	
<b>GENERAL SERVICE COST CENTERS</b>							
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	380,975			13.00
14.00	01400	0	0	0	0		14.00
15.00	01500	0	0	0	0	1,000	15.00
16.00	01600	0	0	0	0	0	16.00
17.00	01700	0	0	0	0	0	17.00
17.01	01702	0	0	0	0	0	17.01
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
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	0	0	278,393	0	0	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
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	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	72,478	0	0	65.00
66.00	06600	0	0	16,898	0	0	66.00
67.00	06700	0	0	8,584	0	0	67.00
68.00	06800	0	0	4,622	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	1,000	73.00
74.00	07400	0	0	0	0	0	74.00
75.00	07500	0	0	0	0	0	75.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		0	0	380,975	0	1,000	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
193.00	19300	0	0	0	0	0	193.00
193.01	19302	0	0	0	0	0	193.01
193.02	19301	0	0	0	0	0	193.02
200.00							200.00
201.00							201.00
202.00		0	0	2,038,971	0	5,251,535	202.00
203.00		0.000000	0.000000	5.351981	0.000000	5,251.535000	203.00
204.00		0	0	186,841	0	151,556	204.00
205.00		0.000000	0.000000	0.490429	0.000000	151.556000	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 152020

Period:  
From 07/01/2013  
To 06/30/2014

Worksheet B-1

Date/Time Prepared:  
11/19/2014 12:21 pm

Cost Center Description		MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	PASTORAL CARE (TOTAL PATIENT DAYS)	OTHER GENERAL SERVICE (SPECIFY) (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
		16.00	17.00	17.01	18.00	19.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
12.00	01200	MAINTENANCE OF PERSONNEL					12.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	122,050,926				16.00
17.00	01700	SOCIAL SERVICE	0	22,113			17.00
17.01	01702	PASTORAL CARE	0	0	22,113		17.01
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	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
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	44,308,521	22,113	22,113	0	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	3,509,144	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	2,215,285	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	543,909	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	11,150,942	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.	861,354	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	31,222,301	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,832,229	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,400,177	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	978,139	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	301,973	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	35,585	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	19,719,766	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	1,971,601	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		SUBTOTALS (SUM OF LINES 1-117)	122,050,926	22,113	22,113	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
193.01	19302	MARKETING	0	0	0	0	193.01
193.02	19301	VACANT SPACE	0	0	0	0	193.02
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	554,241	242,275	122,781	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.004541	10.956225	5.552435	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	34,727	17,919	18,827	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000285	0.810338	0.851400	0.000000	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 152020

Period:  
From 07/01/2013  
To 06/30/2014

Worksheet B-1

Date/Time Prepared:  
11/19/2014 12:21 pm

Cost Center Description	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS		PARAMED PRGM (ASSIGNED TIME)		
		SERVICES-SALARY & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)			
		20.00	21.00			
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00 00500	ADMINISTRATIVE & GENERAL					5.00
6.00 00600	MAINTENANCE & REPAIRS					6.00
7.00 00700	OPERATION OF PLANT					7.00
8.00 00800	LAUNDRY & LINEN SERVICE					8.00
9.00 00900	HOUSEKEEPING					9.00
10.00 01000	DIETARY					10.00
11.00 01100	CAFETERIA					11.00
12.00 01200	MAINTENANCE OF PERSONNEL					12.00
13.00 01300	NURSING ADMINISTRATION					13.00
14.00 01400	CENTRAL SERVICES & SUPPLY					14.00
15.00 01500	PHARMACY					15.00
16.00 01600	MEDICAL RECORDS & LIBRARY					16.00
17.00 01700	SOCIAL SERVICE					17.00
17.01 01702	PASTORAL CARE					17.01
18.00 01850	OTHER GENERAL SERVICE (SPECIFY)					18.00
19.00 01900	NONPHYSICIAN ANESTHETISTS					19.00
20.00 02000	NURSING SCHOOL	0				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 PRGM-(SPECIFY)				0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	0	0	0	0	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
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
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	0	0	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
193.00 19300	NONPAID WORKERS	0	0	0	0	193.00
193.01 19302	MARKETING	0	0	0	0	193.01
193.02 19301	VACANT SPACE	0	0	0	0	193.02
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	0	0	0	0	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.000000	0.000000	0.000000	0.000000	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	0	0	0	0	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000000	0.000000	0.000000	0.000000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 152020

Period:  
From 07/01/2013  
To 06/30/2014

Worksheet C  
Part I  
Date/Time Prepared:  
11/19/2014 12:21 pm

		Title XVIII		Hospital		PPS	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE Disallowance	Total Costs		
			1.00	2.00	3.00		4.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS	22,000,858		22,000,858	0	22,000,858	30.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	667,725		667,725	0	667,725	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	560,387		560,387	0	560,387	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	286,039		286,039	0	286,039	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	882,641		882,641	0	882,641	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.	158,824		158,824	0	158,824	63.00
64.00	06400 INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	6,265,917	0	6,265,917	0	6,265,917	65.00
66.00	06600 PHYSICAL THERAPY	994,797	0	994,797	0	994,797	66.00
67.00	06700 OCCUPATIONAL THERAPY	525,880	0	525,880	0	525,880	67.00
68.00	06800 SPEECH PATHOLOGY	342,322	0	342,322	0	342,322	68.00
69.00	06900 ELECTROCARDIOLOGY	275,849		275,849	0	275,849	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	2,999		2,999	0	2,999	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	5,341,082		5,341,082	0	5,341,082	73.00
74.00	07400 RENAL DIALYSIS	702,225		702,225	0	702,225	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0		0	0	0	75.00
200.00	Subtotal (see instructions)	39,007,545	0	39,007,545	0	39,007,545	200.00
201.00	Less Observation Beds	0		0	0	0	201.00
202.00	Total (see instructions)	39,007,545	0	39,007,545	0	39,007,545	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 152020

Period:  
From 07/01/2013  
To 06/30/2014

Worksheet C  
Part I  
Date/Time Prepared:  
11/19/2014 12:21 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
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	44,308,521		44,308,521		30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,509,144	0	3,509,144	0.190281	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	2,202,169	13,116	2,215,285	0.252964	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	533,283	10,626	543,909	0.525895	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	11,149,735	1,207	11,150,942	0.079154	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.	861,354	0	861,354	0.184389	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	31,110,860	111,441	31,222,301	0.200687	65.00
66.00	06600	PHYSICAL THERAPY	2,832,229	0	2,832,229	0.351242	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,400,177	0	2,400,177	0.219101	67.00
68.00	06800	SPEECH PATHOLOGY	978,139	0	978,139	0.349973	68.00
69.00	06900	ELECTROCARDIOLOGY	301,973	0	301,973	0.913489	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	35,585	0	35,585	0.084277	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	19,719,442	324	19,719,766	0.270849	73.00
74.00	07400	RENAL DIALYSIS	1,971,601	0	1,971,601	0.356170	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	75.00
200.00		Subtotal (see instructions)	121,914,212	136,714	122,050,926		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	121,914,212	136,714	122,050,926		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 152020	Period: From 07/01/2013 To 06/30/2014	Worksheet C Part I Date/Time Prepared: 11/19/2014 12:21 pm
		Title XVIII	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio	
		11.00	
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS		30.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0.190281	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	0.252964	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	55.00
56.00	05600 RADIOISOTOPE	0.000000	56.00
57.00	05700 CT SCAN	0.525895	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	0.079154	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.	0.184389	63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	64.00
65.00	06500 RESPIRATORY THERAPY	0.200687	65.00
66.00	06600 PHYSICAL THERAPY	0.351242	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.219101	67.00
68.00	06800 SPEECH PATHOLOGY	0.349973	68.00
69.00	06900 ELECTROCARDIOLOGY	0.913489	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.084277	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	0.270849	73.00
74.00	07400 RENAL DIALYSIS	0.356170	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000	75.00
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: 152020

Period:  
From 07/01/2013  
To 06/30/2014

Worksheet C  
Part I  
Date/Time Prepared:  
11/19/2014 12:21 pm

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	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	22,000,858		22,000,858	0	22,000,858 30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	667,725		667,725	0	667,725 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	560,387		560,387	0	560,387 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	286,039		286,039	0	286,039 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	882,641		882,641	0	882,641 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.	158,824		158,824	0	158,824 63.00
64.00	06400 INTRAVENOUS THERAPY	0		0	0	0 64.00
65.00	06500 RESPIRATORY THERAPY	6,265,917	0	6,265,917	0	6,265,917 65.00
66.00	06600 PHYSICAL THERAPY	994,797	0	994,797	0	994,797 66.00
67.00	06700 OCCUPATIONAL THERAPY	525,880	0	525,880	0	525,880 67.00
68.00	06800 SPEECH PATHOLOGY	342,322	0	342,322	0	342,322 68.00
69.00	06900 ELECTROCARDIOLOGY	275,849		275,849	0	275,849 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	2,999		2,999	0	2,999 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	5,341,082		5,341,082	0	5,341,082 73.00
74.00	07400 RENAL DIALYSIS	702,225		702,225	0	702,225 74.00
75.00	07500 ASC (NON-DISTINCT PART)	0		0	0	0 75.00
200.00	Subtotal (see instructions)	39,007,545	0	39,007,545	0	39,007,545 200.00
201.00	Less Observation Beds	0		0	0	0 201.00
202.00	Total (see instructions)	39,007,545	0	39,007,545	0	39,007,545 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 152020

Period:  
From 07/01/2013  
To 06/30/2014

Worksheet C  
Part I  
Date/Time Prepared:  
11/19/2014 12:21 pm

Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	44,308,521		44,308,521			30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	3,509,144	0	3,509,144	0.190281	0.000000	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	2,202,169	13,116	2,215,285	0.252964	0.000000	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0	0.000000	0.000000	55.00
56.00	05600 RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
57.00	05700 CT SCAN	533,283	10,626	543,909	0.525895	0.000000	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000 LABORATORY	11,149,735	1,207	11,150,942	0.079154	0.000000	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0.000000	0.000000	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0.000000	0.000000	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	861,354	0	861,354	0.184389	0.000000	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
65.00	06500 RESPIRATORY THERAPY	31,110,860	111,441	31,222,301	0.200687	0.000000	65.00
66.00	06600 PHYSICAL THERAPY	2,832,229	0	2,832,229	0.351242	0.000000	66.00
67.00	06700 OCCUPATIONAL THERAPY	2,400,177	0	2,400,177	0.219101	0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	978,139	0	978,139	0.349973	0.000000	68.00
69.00	06900 ELECTROCARDIOLOGY	301,973	0	301,973	0.913489	0.000000	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	35,585	0	35,585	0.084277	0.000000	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	19,719,442	324	19,719,766	0.270849	0.000000	73.00
74.00	07400 RENAL DIALYSIS	1,971,601	0	1,971,601	0.356170	0.000000	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	75.00
200.00	Subtotal (see instructions)	121,914,212	136,714	122,050,926			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	121,914,212	136,714	122,050,926			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 152020	Period: From 07/01/2013 To 06/30/2014	Worksheet C Part I Date/Time Prepared: 11/19/2014 12:21 pm
		Title XIX	Hospital	Cost

Cost Center Description		PPS Inpatient Ratio	
		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
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: 152020		Period: From 07/01/2013 To 06/30/2014		Worksheet D Part I Date/Time Prepared: 11/19/2014 12:21 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	PPS Per Diem (col. 3 / col. 4)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	2,192,049	0	2,192,049	22,113	99.13	
200.00	Total (Lines 30-199)	2,192,049		2,192,049	22,113	200.00	
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	13,656	1,353,719	30.00			
200.00	Total (Lines 30-199)	13,656	1,353,719	200.00			

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 152020	Period: From 07/01/2013 To 06/30/2014	Worksheet D Part II Date/Time Prepared: 11/19/2014 12:21 pm
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	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	29,320	3,509,144	0.008355	2,705,368	22,603	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	39,963	2,215,285	0.018040	1,419,178	25,602	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	13,163	543,909	0.024201	318,274	7,703	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	24,995	11,150,942	0.002242	7,034,466	15,771	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.	3,131	861,354	0.003635	471,507	1,714	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	162,776	31,222,301	0.005213	19,650,932	102,440	65.00
66.00	06600 PHYSICAL THERAPY	41,744	2,832,229	0.014739	1,688,632	24,889	66.00
67.00	06700 OCCUPATIONAL THERAPY	29,673	2,400,177	0.012363	1,398,573	17,291	67.00
68.00	06800 SPEECH PATHOLOGY	24,420	978,139	0.024966	594,311	14,838	68.00
69.00	06900 ELECTROCARDIOLOGY	5,200	301,973	0.017220	171,651	2,956	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	63	35,585	0.001770	23,304	41	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	157,176	19,719,766	0.007970	11,415,179	90,979	73.00
74.00	07400 RENAL DIALYSIS	13,480	1,971,601	0.006837	1,369,073	9,360	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
200.00	Total (lines 50-199)	545,104	77,742,405		48,260,448	336,187	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 152020		Period: From 07/01/2013 To 06/30/2014		Worksheet D Part III Date/Time Prepared: 11/19/2014 12:21 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	
200.00		Total (lines 30-199)	0	0	0	0	0	
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)		
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	22,113	0.00	13,656	0	30.00	
200.00		Total (lines 30-199)	22,113		13,656	0	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 152020	Period: From 07/01/2013 To 06/30/2014	Worksheet D Part IV Date/Time Prepared: 11/19/2014 12:21 pm
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Cost Center Description	Title XVIII				Hospital	PPS
	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	
<b>ANCILLARY SERVICE COST CENTERS</b>						
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: 152020	Period: From 07/01/2013 To 06/30/2014	Worksheet D Part IV Date/Time Prepared: 11/19/2014 12:21 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)	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	3,509,144	0.000000	0.000000	2,705,368	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	2,215,285	0.000000	0.000000	1,419,178	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	543,909	0.000000	0.000000	318,274	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	11,150,942	0.000000	0.000000	7,034,466	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	861,354	0.000000	0.000000	471,507	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	31,222,301	0.000000	0.000000	19,650,932	65.00
66.00	06600 PHYSICAL THERAPY	0	2,832,229	0.000000	0.000000	1,688,632	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	2,400,177	0.000000	0.000000	1,398,573	67.00
68.00	06800 SPEECH PATHOLOGY	0	978,139	0.000000	0.000000	594,311	68.00
69.00	06900 ELECTROCARDIOLOGY	0	301,973	0.000000	0.000000	171,651	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	35,585	0.000000	0.000000	23,304	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	19,719,766	0.000000	0.000000	11,415,179	73.00
74.00	07400 RENAL DIALYSIS	0	1,971,601	0.000000	0.000000	1,369,073	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	77,742,405			48,260,448	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 152020	Period: From 07/01/2013 To 06/30/2014	Worksheet D Part IV Date/Time Prepared: 11/19/2014 12:21 pm
Title XVIII		Hospital	PPS

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	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	0	13,116	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	0	10,626	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	0	1,207	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.	0	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	111,441	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	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	0	180	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0	75.00
200.00	Total (lines 50-199)	0	136,570	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 152020	Period: From 07/01/2013 To 06/30/2014	Worksheet D Part V Date/Time Prepared: 11/19/2014 12:21 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	0.190281	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.252964	13,116	0	3,318	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	55.00
56.00	05600 RADIOISOTOPE	0.000000	0	0	0	56.00
57.00	05700 CT SCAN	0.525895	10,626	0	5,588	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	59.00
60.00	06000 LABORATORY	0.079154	1,207	0	96	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	0	60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	0	0	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.184389	0	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.200687	111,441	0	22,365	65.00
66.00	06600 PHYSICAL THERAPY	0.351242	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.219101	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.349973	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.913489	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.084277	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.270849	180	0	144	73.00
74.00	07400 RENAL DIALYSIS	0.356170	0	0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000	0	0	0	75.00
200.00	Subtotal (see instructions)		136,570	0	144	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		136,570	0	144	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 152020	Period: From 07/01/2013 To 06/30/2014	Worksheet D Part V Date/Time Prepared: 11/19/2014 12:21 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	39	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	39	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	0	39	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 152020		Period: From 07/01/2013 To 06/30/2014		Worksheet D Part I Date/Time Prepared: 11/19/2014 12:21 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)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	2,192,049	0	2,192,049	22,113	99.13	
200.00	Total (Lines 30-199)	2,192,049		2,192,049	22,113	200.00	
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	842	83,467				
200.00	Total (Lines 30-199)	842	83,467				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 152020	Period: From 07/01/2013 To 06/30/2014	Worksheet D Part II Date/Time Prepared: 11/19/2014 12:21 pm
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Cost Center Description		Title XIX			Hospital	Cost		
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	29,320	3,509,144	0.008355	105,879	885	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	39,963	2,215,285	0.018040	121,274	2,188	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	13,163	543,909	0.024201	31,730	768	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	24,995	11,150,942	0.002242	449,626	1,008	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.	3,131	861,354	0.003635	14,924	54	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	162,776	31,222,301	0.005213	1,146,321	5,976	65.00
66.00	06600	PHYSICAL THERAPY	41,744	2,832,229	0.014739	116,092	1,711	66.00
67.00	06700	OCCUPATIONAL THERAPY	29,673	2,400,177	0.012363	106,905	1,322	67.00
68.00	06800	SPEECH PATHOLOGY	24,420	978,139	0.024966	37,269	930	68.00
69.00	06900	ELECTROCARDIOLOGY	5,200	301,973	0.017220	5,436	94	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	63	35,585	0.001770	0	0	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	157,176	19,719,766	0.007970	940,893	7,499	73.00
74.00	07400	RENAL DIALYSIS	13,480	1,971,601	0.006837	94,231	644	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
200.00		Total (lines 50-199)	545,104	77,742,405		3,170,580	23,079	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 152020		Period: From 07/01/2013 To 06/30/2014		Worksheet D Part III Date/Time Prepared: 11/19/2014 12:21 pm	
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Hospital	Cost	
			1.00	2.00	3.00	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			6.00	7.00	8.00	9.00		
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
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	22,113	0.00	842	0	0	30.00
200.00		Total (lines 30-199)	22,113		842	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 152020

Period:  
From 07/01/2013  
To 06/30/2014

Worksheet D  
Part IV  
Date/Time Prepared:  
11/19/2014 12:21 pm

Cost Center Description		Title XIX				Hospital	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	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					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: 152020	Period: From 07/01/2013 To 06/30/2014	Worksheet D Part IV Date/Time Prepared: 11/19/2014 12:21 pm
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Cost Center Description	Title XIX			Hospital		Inpatient Program Charges	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)				
	6.00	7.00	8.00	9.00	10.00			
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	3,509,144	0.000000	0.000000	105,879	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	2,215,285	0.000000	0.000000	121,274	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	543,909	0.000000	0.000000	31,730	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	11,150,942	0.000000	0.000000	449,626	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	861,354	0.000000	0.000000	14,924	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	31,222,301	0.000000	0.000000	1,146,321	65.00
66.00	06600	PHYSICAL THERAPY	0	2,832,229	0.000000	0.000000	116,092	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,400,177	0.000000	0.000000	106,905	67.00
68.00	06800	SPEECH PATHOLOGY	0	978,139	0.000000	0.000000	37,269	68.00
69.00	06900	ELECTROCARDIOLOGY	0	301,973	0.000000	0.000000	5,436	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	35,585	0.000000	0.000000	0	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	19,719,766	0.000000	0.000000	940,893	73.00
74.00	07400	RENAL DIALYSIS	0	1,971,601	0.000000	0.000000	94,231	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	77,742,405			3,170,580	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 152020

Period:  
From 07/01/2013  
To 06/30/2014

Worksheet D  
Part IV  
Date/Time Prepared:  
11/19/2014 12:21 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)		
		11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	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	0	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	0	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	0	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.	0	0	0		63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0		64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600 PHYSICAL THERAPY	0	0	0		66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	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	0	0	0		73.00
74.00	07400 RENAL DIALYSIS	0	0	0		74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0		75.00
200.00	Total (lines 50-199)	0	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 152020	Period: From 07/01/2013 To 06/30/2014	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 11/19/2014 12:21 pm
Cost Center Description				PPS
				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		22,113	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		22,113	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)		22,113	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)		13,656	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
<b>SWING BED ADJUSTMENT</b>				
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)		22,000,858	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)		22,000,858	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
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)		22,000,858	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		994.93	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		13,586,764	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)		13,586,764	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 152020	Period: From 07/01/2013 To 06/30/2014	Worksheet D-1 Date/Time Prepared: 11/19/2014 12:21 pm
Cost Center Description			Title XVIII		Hospital
Intensive Care Type Inpatient Hospital Units			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
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)				10,474,312 48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				24,061,076 49.00
<b>PASS THROUGH COST ADJUSTMENTS</b>					
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)				1,353,719 50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				336,187 51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)				1,689,906 52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				22,371,170 53.00
<b>TARGET AMOUNT AND LIMIT COMPUTATION</b>					
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
<b>PROGRAM INPATIENT ROUTINE SWING BED COST</b>					
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
<b>PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY</b>					
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
<b>PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>					
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: 152020		Period: From 07/01/2013 To 06/30/2014		Worksheet D-1 Date/Time Prepared: 11/19/2014 12:21 pm	
Cost Center Description		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)	PPS
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	2,192,049	22,000,858	0.099635	0	0	90.00
91.00	Nursing School cost	0	22,000,858	0.000000	0	0	91.00
92.00	Allied health cost	0	22,000,858	0.000000	0	0	92.00
93.00	All other Medical Education	0	22,000,858	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 152020	Period: From 07/01/2013 To 06/30/2014	Worksheet D-1 Date/Time Prepared: 11/19/2014 12:21 pm
Cost Center Description		Title XIX	Hospital	Cost
		1.00		
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		22,113	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		22,113	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)		22,113	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)		842	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
<b>SWING BED ADJUSTMENT</b>				
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)		22,000,858	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)		22,000,858	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
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)		22,000,858	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		994.93	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		837,731	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)		837,731	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 152020	Period: From 07/01/2013 To 06/30/2014	Worksheet D-1 Date/Time Prepared: 11/19/2014 12:21 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)
Title XIX		1.00	2.00	3.00	4.00	5.00
Hospital						
Cost						
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)					706,516 48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,544,247 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: 152020		Period: From 07/01/2013 To 06/30/2014		Worksheet D-1 Date/Time Prepared: 11/19/2014 12:21 pm	
Cost Center Description		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	2,192,049	22,000,858	0.099635	0	0	90.00
91.00	Nursing School cost	0	22,000,858	0.000000	0	0	91.00
92.00	Allied health cost	0	22,000,858	0.000000	0	0	92.00
93.00	All other Medical Education	0	22,000,858	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 152020	Period: From 07/01/2013 To 06/30/2014	Worksheet D-3 Date/Time Prepared: 11/19/2014 12:21 pm	
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		26,000,305		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.190281	2,705,368	514,780	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	0.252964	1,419,178	359,001	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	0.525895	318,274	167,379	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	0.079154	7,034,466	556,806	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.	0.184389	471,507	86,941	63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.200687	19,650,932	3,943,687	65.00
66.00	06600 PHYSICAL THERAPY	0.351242	1,688,632	593,118	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.219101	1,398,573	306,429	67.00
68.00	06800 SPEECH PATHOLOGY	0.349973	594,311	207,993	68.00
69.00	06900 ELECTROCARDIOLOGY	0.913489	171,651	156,801	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.084277	23,304	1,964	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	0.270849	11,415,179	3,091,790	73.00
74.00	07400 RENAL DIALYSIS	0.356170	1,369,073	487,623	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)		48,260,448	10,474,312	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)		48,260,448		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 152020	Period: From 07/01/2013 To 06/30/2014	Worksheet D-3 Date/Time Prepared: 11/19/2014 12:21 pm	
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		1,878,385		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.190281	105,879	20,147	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	0.252964	121,274	30,678	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	0.525895	31,730	16,687	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	0.079154	449,626	35,590	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.	0.184389	14,924	2,752	63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.200687	1,146,321	230,052	65.00
66.00	06600 PHYSICAL THERAPY	0.351242	116,092	40,776	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.219101	106,905	23,423	67.00
68.00	06800 SPEECH PATHOLOGY	0.349973	37,269	13,043	68.00
69.00	06900 ELECTROCARDIOLOGY	0.913489	5,436	4,966	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.084277	0	0	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	0.270849	940,893	254,840	73.00
74.00	07400 RENAL DIALYSIS	0.356170	94,231	33,562	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)		3,170,580	706,516	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)		3,170,580		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 152020	Period: From 07/01/2013 To 06/30/2014	Worksheet E Part B Date/Time Prepared: 11/19/2014 12:21 pm
		Title XVII	Hospital	PPS
				1.00
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		39	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		31,416	2.00
3.00	PPS payments		4,405	3.00
4.00	Outlier payment (see instructions)		2,486	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)		39	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges		144	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)		144	14.00
<b>Customary charges</b>				
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)		144	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		105	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)		39	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		6,891	24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		1,146	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)		5,784	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)		5,784	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		5,784	32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
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)		5,784	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00			0	39.00
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		5,784	40.00
40.01	Sequestration adjustment (see instructions)		116	40.01
41.00	Interim payments		5,658	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		10	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 152020

Period:  
From 07/01/2013  
To 06/30/2014

Worksheet E-1  
Part I  
Date/Time Prepared:  
11/19/2014 12:21 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		21,652,042		5,658	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER	01/29/2014	222,400		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)		222,400		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)		21,874,442		5,658	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		99,730		10	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		21,974,172		5,668	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: 152020	Period: From 07/01/2013 To 06/30/2014	Worksheet E-3 Part IV Date/Time Prepared: 11/19/2014 12:21 pm
		Title XVIII	Hospital	PPS
		1.00		
<b>PART IV - MEDICARE PART A SERVICES - LTCH PPS</b>				
1.00	Net Federal PPS Payments (see instructions)		20,091,528	1.00
2.00	Outlier Payments		3,859,874	2.00
3.00	Total PPS Payments (sum of lines 1 and 2)		23,951,402	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 physicians' services in a teaching hospital (see instructions)		0	6.00
7.00	Subtotal (see instructions)		23,951,402	7.00
8.00	Primary payer payments		163,940	8.00
9.00	Subtotal (line 7 less line 8)		23,787,462	9.00
10.00	Deductibles		31,168	10.00
11.00	Subtotal (line 9 minus line 10)		23,756,294	11.00
12.00	Coinsurance		1,824,344	12.00
13.00	Subtotal (line 11 minus line 12)		21,931,950	13.00
14.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		754,883	14.00
15.00	Adjusted reimbursable bad debts (see instructions)		490,674	15.00
16.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		736,412	16.00
17.00	Subtotal (sum of lines 13 and 15)		22,422,624	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)		22,422,624	22.00
22.01	Sequestration adjustment (see instructions)		448,452	22.01
23.00	Interim payments		21,874,442	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)		99,730	25.00
26.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	26.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
50.00	Original outlier amount from Wkst. E-3, Pt IV, line 3 (see instructions)		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 (see instructions)		0.00	52.00
53.00	Time Value of Money (see instructions)		0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 152020	Period: From 07/01/2013 To 06/30/2014	Worksheet E-3 Part VII Date/Time Prepared: 11/19/2014 12:21 pm	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
<b>PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES</b>					
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>					
1.00	Inpatient hospital/SNF/NF services		1,544,247		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		1,544,247	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		1,544,247	0	7.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>					
<b>Reasonable Charges</b>					
8.00	Routine service charges		1,878,385		8.00
9.00	Ancillary service charges		3,170,580	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)		5,048,965	0	12.00
<b>CUSTOMARY CHARGES</b>					
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)		5,048,965	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		3,504,718	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 physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		1,544,247	0	21.00
<b>PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.</b>					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		1,544,247	0	29.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		1,544,247	0	31.00
32.00	Deductibles		0		32.00
33.00	Coinurance		0		33.00
34.00	Allowable bad debts (see instructions)		0		34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		1,544,247	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		37.00
38.00	Subtotal (line 36 ± line 37)		1,544,247	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		1,544,247	0	40.00
41.00	Interim payments		1,544,247	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0		42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0		43.00

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

Provider CCN: 152020

Period:  
From 07/01/2013  
To 06/30/2014

Worksheet G

Date/Time Prepared:  
11/19/2014 12:21 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>CURRENT ASSETS</b>						
1.00	Cash on hand in banks	0	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	17,274,814	0	0	0	4.00
5.00	Other receivable	1,415,266	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-8,339,784	0	0	0	6.00
7.00	Inventory	411,309	0	0	0	7.00
8.00	Prepaid expenses	26,096	0	0	0	8.00
9.00	Other current assets	121,086	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	10,908,787	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	847,629	0	0	0	12.00
13.00	Land improvements	3,157	0	0	0	13.00
14.00	Accumulated depreciation	-1,920	0	0	0	14.00
15.00	Buildings	17,009,975	0	0	0	15.00
16.00	Accumulated depreciation	-6,332,432	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	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	4,957,594	0	0	0	23.00
24.00	Accumulated depreciation	-3,408,317	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)	13,075,686	0	0	0	30.00
<b>OTHER ASSETS</b>						
31.00	Investments	75,143,584	15,608	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	13,010	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	75,156,594	15,608	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	99,141,067	15,608	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	1,822,631	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,494,454	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	4,677,773	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	7,994,858	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
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	416,651	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	416,651	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	8,411,509	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	90,729,558				52.00
53.00	Specific purpose fund		15,608			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	90,729,558	15,608	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	99,141,067	15,608	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 152020

Period:  
From 07/01/2013  
To 06/30/2014

Worksheet G-1

Date/Time Prepared:  
11/19/2014 12:21 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		82,028,972		18,264		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		19,264,077				2.00
3.00	Total (sum of line 1 and line 2)		101,293,049		18,264		3.00
4.00	DONATIONS	0		20,000		0	4.00
5.00	TRANSFER RESTR CONTR USED FOR PROP	17,181		0		0	5.00
6.00	TEMPORARILY RESTRICTED OTHER	0		6,078		0	6.00
7.00	ROUNDING	3		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		17,184		26,078		10.00
11.00	Subtotal (line 3 plus line 10)		101,310,233		44,342		11.00
12.00	TRANSFER TO AFFILIATES	10,574,597		0		0	12.00
13.00	TEMP RESTRICTED RELEASE TO OPERATING	0		11,552		0	13.00
14.00	TEMP RESTRICTED RELEASED CAPITAL	0		17,181		0	14.00
15.00	UNRESTRICTED OTHER	6,078		0		0	15.00
16.00	ROUNDING	0		1		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		10,580,675		28,734		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		90,729,558		15,608		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	DONATIONS		0				4.00
5.00	TRANSFER RESTR CONTR USED FOR PROP		0				5.00
6.00	TEMPORARILY RESTRICTED OTHER		0				6.00
7.00	ROUNDING		0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	TRANSFER TO AFFILIATES		0				12.00
13.00	TEMP RESTRICTED RELEASE TO OPERATING		0				13.00
14.00	TEMP RESTRICTED RELEASED CAPITAL		0				14.00
15.00	UNRESTRICTED OTHER		0				15.00
16.00	ROUNDING		0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 152020

Period:  
From 07/01/2013  
To 06/30/2014

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
11/19/2014 12:21 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
General Inpatient Routine Services					
1.00	Hospital	44,308,521		44,308,521	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)	44,308,521		44,308,521	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)	44,308,521		44,308,521	17.00
18.00	Ancillary services	77,605,691	136,714	77,742,405	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)	121,914,212	136,714	122,050,926	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		36,911,270		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	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		36,911,270		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 152020

Period:  
From 07/01/2013  
To 06/30/2014

Worksheet G-3

Date/Time Prepared:  
11/19/2014 12:21 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	122,050,926	1.00
2.00	Less contractual allowances and discounts on patients' accounts	73,773,958	2.00
3.00	Net patient revenues (line 1 minus line 2)	48,276,968	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	36,911,270	4.00
5.00	Net income from service to patients (line 3 minus line 4)	11,365,698	5.00
<b>OTHER INCOME</b>			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	2,906,326	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	84,752	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	7,016	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER-ASSETS RELEASED FROM RESTR.	11,552	24.00
24.01	OTHER - NURSING ADMIN MISC INCOME	21,750	24.01
24.02	OTHER - WOUND CARE MISC INCOME	-13,250	24.02
24.03	OTHER - UNREALIZED GAIN	4,880,233	24.03
24.04		0	24.04
24.05		0	24.05
24.06		0	24.06
25.00	Total other income (sum of lines 6-24)	7,898,379	25.00
26.00	Total (line 5 plus line 25)	19,264,077	26.00
27.00		0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	19,264,077	29.00

CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B		Provider CCN: 152020	Period: From 07/01/2013 To 06/30/2014	Worksheet I-5 Date/Time Prepared: 11/19/2014 12:21 pm
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		1.00	2.00	
<b>PART I - CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B</b>				
1.00	Total expenses related to care of program beneficiaries (see instructions)		0	1.00
2.00	Total payment due (from Wkst. 1-4, col. 6, line 11) (see instructions)			2.00
2.01	Total payment due (from Wkst. 1-4, col. 6.01, line 11) (see instructions)	0	0	2.01
2.02	Total payment due (from Wkst. 1-4, col. 6.02, line 11) (see instructions)	0	0	2.02
2.03	Total payment due (see instructions)	0	0	2.03
2.04	Outlier payments	0		2.04
3.00	Deductibles billed to Medicare (Part B) patients (see instructions)			3.00
3.01	Deductibles billed to Medicare (Part B) patients (see instructions)	0	0	3.01
3.02	Deductibles billed to Medicare (Part B) patients (see instructions)	0	0	3.02
3.03	Total deductibles billed to Medicare (Part B) patients (see instructions)	0	0	3.03
4.00	Coinsurance billed to Medicare (Part B) patients			4.00
4.01	Coinsurance billed to Medicare (Part B) patients (see instructions)	0	0	4.01
4.02	Coinsurance billed to Medicare (Part B) patients (see instructions)	0	0	4.02
4.03	Total coinsurance billed to Medicare (Part B) patients (see instructions)	0	0	4.03
5.00	Bad debts for deductibles and coinsurance, net of bad debt recoveries	0	0	5.00
5.01	Transition period 1 (75-25%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2011 but before 1/1/2012	0	0	5.01
5.02	Transition period 2 (50-50%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2012 but before 1/1/2013	0	0	5.02
5.03	Transition period 3 (25-75%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2013 but before 1/1/2014	0	0	5.03
5.04	100% PPS bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2014	0	0	5.04
5.05	Total bad debts (sum of line 5 through line 5.04)	0	0	5.05
6.00	Allowable bad debts (see instructions)	0		6.00
7.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0		7.00
8.00	Net deductibles and coinsurance billed to Medicare (Part B) patients (see instructions)	0	0	8.00
9.00	Program payment (see instructions)	0	0	9.00
10.00	Unrecovered from Medicare (Part B) patients (see instructions)			10.00
11.00	Reimbursable bad debts (see instructions) (transfer to Worksheet E, Part B, line 33)	0		11.00
<b>PART II - CALCULATION OF FACILITY SPECIFIC COMPOSITE COST PERCENTAGE</b>				
12.00	Total allowable expenses (see instructions)		0	12.00
13.00	Total composite costs (from Wkst. 1-4, col. 2, line 11)		0	13.00
14.00	Facility specific composite cost percentage (line 13 divided by line 12)		0.000000	14.00