

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: 150010	Period: From 07/01/2012 To 06/30/2013	Worksheet S Parts I-III Date/Time Prepared: 11/26/2013 6:08 pm
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PART I - COST REPORT STATUS			
Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report	Date: 11/26/2013 Time: 6:08 pm	
	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.		
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. JOSEPH HOSPITAL & HEALTH CENTR (150010) for the cost reporting period beginning 07/01/2012 and ending 06/30/2013 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(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			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	372,786	13,249	1,507,473	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	-13,832	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	358,954	13,249	1,507,473	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA			Provider CCN: 150010		Period: From 07/01/2012 To 06/30/2013		Worksheet S-2 Part I Date/Time Prepared: 11/26/2013 6:05 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: 1907 WEST SYCAMORE			PO Box:		1.00
City: KOKOMO		State: IN	Zip Code: 46901-	County: HOWARD	

	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. JOSEPH HOSPITAL & HEALTH CENTR	150010	29020	1	07/01/1966	N	P	0	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF	ST. JOSEPH ACUTE REHAB UNIT	15T010	29020	5	07/01/2002	N	P	0	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 - FOHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

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

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

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
	1.00	2.00	3.00	4.00	5.00	6.00		
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	1,612	1,135	0	5	2,653	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.	172	97	0	0	1	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: 150010	Period: From 07/01/2012 To 06/30/2013	Worksheet S-2 Part I Date/Time Prepared: 11/26/2013 6:05 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)	N				39.00
		V 1.00	XVIII 2.00	XIX 3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	Y	N		45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N		46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N		47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N				56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.					57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.					58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N				59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	Y				60.00
		Y/N 1.00	IME 2.00	Direct GME 3.00	IME 4.00	Direct GME 5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00		61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN and general surgery) added as a result of section 5503. (see instructions)		0.00	0.00		61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00		61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00		61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00		61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00		61.06
		Program Name 1.00	Program Code 2.00	Unweighted IME FTE Count 3.00	Unweighted Direct GME FTE Count 4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.10

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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	0.000000	64.00
		Program Name	Program Code	Unweighted FTEs Nonprovi der Site	Unweighted FTEs in Hospi tal	Ratio (col. 3/ (col. 3 + col. 4))
		1.00	2.00	3.00	4.00	5.00
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00
			Unweighted FTEs 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	0.000000	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	4.00	5.00		
67.00	Enter in column 1 the program name associated with each of your primary care programs in which you trained residents. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000		67.00
					1.00	2.00	3.00
Inpatient Psychiatric Facility PPS							
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N			70.00
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)					0	71.00
Inpatient Rehabilitation Facility PPS							
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			Y			75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			N	N	0	76.00
					1.00		
Long Term Care Hospital PPS							
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.				N		80.00
TEFRA Providers							
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.				N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.						86.00
					V	XIX	
					1.00	2.00	
Title V and XIX Services							
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N	Y		90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	N		91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.				N		92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	N		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	N		94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.				0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.			N	N		96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.				0.00	0.00	97.00
Rural Providers							
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?			N			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)						106.00

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			V	XIX	
			1.00	2.00	
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)				107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		N		108.00
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.				109.00
			1.00	2.00	3.00
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.		N		115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.		N		116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.		Y		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		2		118.00
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	102,548	0		118.01
			1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N		118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.		N	N	120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.		Y		121.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)		Y	15H046	140.00

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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 STREET	PO Box:		Zip Code: 46290		142.00								
143.00	City: INDIANAPOLIS	State: IN		143.00										
						1.00								
144.00	Are provider based physicians' costs included in Worksheet A?						Y 144.00							
145.00	If costs for renal services are claimed on Worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.						Y 145.00							
						1.00								
						2.00								
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.						N 146.00							
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.						N 147.00							
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.						N 148.00							
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.						N 149.00							
		Part A		Part B		Title V		Title XIX						
		1.00		2.00		3.00		4.00						
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)														
155.00	Hospital	N		N		N		N 155.00						
156.00	Subprovider - IPF	N		N		N		N 156.00						
157.00	Subprovider - IRF	N		N		N		N 157.00						
158.00	SUBPROVIDER							158.00						
159.00	SNF	N		N		N		N 159.00						
160.00	HOME HEALTH AGENCY	N		N		N		N 160.00						
161.00	CMHC			N		N		N 161.00						
						1.00								
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		County		State		Zip Code		CBSA		FTE/Campus		
		0		1.00		2.00		3.00		4.00		5.00		
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5										0.00		166.00	
						1.00								
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act														
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.						Y		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)								0 168.00					
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						1.00		169.00					
						Beginning		Ending						
						1.00		2.00						
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)						11/01/2012		01/31/2013		170.00			

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 150010		Period: From 07/01/2012 To 06/30/2013		Worksheet S-2 Part II Date/Time Prepared: 11/26/2013 6:05 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				
		1.00	2.00				
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y					3.00
		Y/N	Type				
		1.00	2.00				
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	09/13/2013			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.	Y					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.			Y			15.00
				Y/N			
				1.00			
PS&R Data							
		Description		Part A		Part B	
		0		Y/N	Date	Y/N	
				1.00	2.00	3.00	
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	10/02/2013	Y			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: 150010	Period: From 07/01/2012 To 06/30/2013	Worksheet S-2 Part II Date/Time Prepared: 11/26/2013 6:05 pm	
	Description	Part A		Part B	
		Y/N	Date	Y/N	
0		1.00	2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions				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.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				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				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				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.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				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.				35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	NANCY	GAYLE		41.00
42.00	Enter the employer/company name of the cost report preparer.	ST. VINCENT HEALTH			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-583-3236	NKGAYLE@STVINCENT.ORG		43.00

		Part B		
		Date		
		4.00		
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	10/02/2013		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.			19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.			21.00
			3.00	
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REIMBURSEMENT MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150010

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

Worksheet S-3
Part I
Date/Time Prepared:
11/26/2013 6:05 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Avai lable	CAH Hours	I/P Days / O/P Vi si ts / Tri ps	
					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	139	50,735	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)		139	50,735	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	13	4,745	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		152	55,480	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	41.00	18	6,570		0	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)		170				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150010

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

Worksheet S-3
Part I
Date/Time Prepared:
11/26/2013 6:05 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)	8,171	988	17,827			1.00
2.00 HMO and other (see instructions)	914	2,566				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	161	97				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)	8,171	988	17,827			7.00
8.00 INTENSIVE CARE UNIT	1,496	0	2,291			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		1,581	1,855			13.00
14.00 Total (see instructions)	9,667	2,569	21,973	0.00	685.23	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	3,272	172	4,404	0.00	27.90	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	713.13	27.00
28.00 Observation Bed Days		39	1,200			28.00
29.00 Ambulance Trips	1,934					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)		270	428			32.00
33.00 LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150010

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

Worksheet S-3
Part I
Date/Time Prepared:
11/26/2013 6:05 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	2,126	875	5,206	1.00
2.00 HMO and other (see instructions)				206			2.00
3.00 HMO IPF Subprovider							3.00
4.00 HMO IRF Subprovider							4.00
5.00 Hospital Adults & Peds. Swing Bed SNF							5.00
6.00 Hospital Adults & Peds. Swing Bed NF							6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)							7.00
8.00 INTENSIVE CARE UNIT							8.00
9.00 CORONARY CARE UNIT							9.00
10.00 BURN INTENSIVE CARE UNIT							10.00
11.00 SURGICAL INTENSIVE CARE UNIT							11.00
12.00 OTHER SPECIAL CARE (SPECIFY)							12.00
13.00 NURSERY							13.00
14.00 Total (see instructions)	0.00	0		2,126	875	5,206	14.00
15.00 CAH visits							15.00
16.00 SUBPROVIDER - IPF							16.00
17.00 SUBPROVIDER - IRF	0.00	0		243	35	324	17.00
18.00 SUBPROVIDER							18.00
19.00 SKILLED NURSING FACILITY							19.00
20.00 NURSING FACILITY							20.00
21.00 OTHER LONG TERM CARE							21.00
22.00 HOME HEALTH AGENCY							22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)							23.00
24.00 HOSPICE							24.00
24.10 HOSPICE (non-distinct part)							24.10
25.00 CMHC - CMHC							25.00
26.00 RURAL HEALTH CLINIC							26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER							26.25
27.00 Total (sum of lines 14-26)	0.00						27.00
28.00 Observation Bed Days							28.00
29.00 Ambulance Trips							29.00
30.00 Employee discount days (see instruction)							30.00
31.00 Employee discount days - IRF							31.00
32.00 Labor & delivery days (see instructions)							32.00
33.00 LTCH non-covered days							33.00

HOSPITAL WAGE INDEX INFORMATION			Provider CCN: 150010		Period: From 07/01/2012 To 06/30/2013		Worksheet S-3 Part II Date/Time Prepared: 11/26/2013 6:05 pm	
	Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)		
	1.00	2.00	3.00	4.00	5.00	6.00		
PART II - WAGE DATA								
SALARIES								
1.00	Total salaries (see instructions)	200.00	39,061,986	0	39,061,986	1,483,305.00	26.33	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		835,493	0	835,493	6,943.00	120.34	5.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office personnel		1,845,516	0	1,845,516	48,084.00	38.38	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		2,475,538	94,160	2,569,698	122,955.00	20.90	10.00
OTHER WAGES & RELATED COSTS								
11.00	Contract labor (see instructions)		650,680	0	650,680	18,480.00	35.21	11.00
12.00	Contract management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract Labor: Physician-Part A - Administrative		332,170	0	332,170	988.00	336.20	13.00
14.00	Home office salaries & wage-related costs		6,550,915	0	6,550,915	122,900.00	53.30	14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
WAGE-RELATED COSTS								
17.00	Wage-related costs (core) (see instructions)		9,035,208	0	9,035,208			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		636,238	0	636,238			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FOHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	421,128	0	421,128	16,480.00	25.55	26.00
27.00	Administrative & General	5.00	7,537,059	0	7,537,059	264,073.00	28.54	27.00
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	931,188	0	931,188	46,872.00	19.87	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	97	0	97	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)		1,635,855	0	1,635,855	76,105.00	21.49	33.00
34.00	Dietary	10.00	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		1,800,790	0	1,800,790	77,259.00	23.31	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	359,832	0	359,832	10,425.00	34.52	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	1,480,728	0	1,480,728	38,030.00	38.94	40.00
41.00	Medical Records & Medical Records Library	16.00	853,094	0	853,094	50,279.00	16.97	41.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150010

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

Worksheet S-3
Part II
Date/Time Prepared:
11/26/2013 6:05 pm

		Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Sal ari es (from Worksheet A-6)	Adjus ted Sal ari es (col . 2 ± col . 3)	Paid Hours Related to Sal ari es in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
42.00	Soci al Servi ce	17.00	419,195	0	419,195	16,165.00	25.93	42.00
43.00	Other General Servi ce	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150010

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

Worksheet S-3
Part III
Date/Time Prepared:
11/26/2013 6:05 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cation of Sal aries (from Worksheet A-6)	Adjusted Sal aries (col . 2 ± col . 3)	Paid Hours Related to Sal aries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	39,817,622	0	39,817,622	1,581,642.00	25.17	1.00
2.00	Excluded area salaries (see instructions)	2,475,538	94,160	2,569,698	122,955.00	20.90	2.00
3.00	Subtotal salaries (line 1 minus line 2)	37,342,084	-94,160	37,247,924	1,458,687.00	25.54	3.00
4.00	Subtotal other wages & related costs (see inst.)	7,533,765	0	7,533,765	142,368.00	52.92	4.00
5.00	Subtotal wage-related costs (see inst.)	9,035,208	0	9,035,208	0.00	24.26	5.00
6.00	Total (sum of lines 3 thru 5)	53,911,057	-94,160	53,816,897	1,601,055.00	33.61	6.00
7.00	Total overhead cost (see instructions)	15,438,966	0	15,438,966	595,688.00	25.92	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 150010	Period: From 07/01/2012 To 06/30/2013	Worksheet S-3 Part IV Date/Time Prepared: 11/26/2013 6:05 pm
			Amount Reported	
			1.00	
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		473,996	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution		0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)		475,893	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)		0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration Fees		0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan		208	6.00
7.00	Employee Managed Care Program Administration Fees		0	7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)		5,732,364	8.00
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		21,344	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		33,512	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)		0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)		371,870	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		160,418	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		0	16.00
TAXES				
17.00	FICA-Employers Portion Only		2,760,017	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		0	19.00
20.00	State or Federal Unemployment Taxes		46,786	20.00
OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))		41,035	21.00
22.00	Day Care Cost and Allowances		0	22.00
23.00	Tuition Reimbursement		20,532	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		10,137,975	24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 150010

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

Worksheet S-3
Part V
Date/Time Prepared:
11/26/2013 6:05 pm

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 150010	Period: From 07/01/2012 To 06/30/2013	Worksheet S-10 Date/Time Prepared: 11/26/2013 6:05 pm
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				1.00	
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.266559		1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		3,641,462		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		N		3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?				4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		0		5.00
6.00	Medicaid charges		44,173,604		6.00
7.00	Medicaid cost (line 1 times line 6)		11,774,872		7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		8,133,410		8.00
State Children's Health Insurance Program (SCHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone SCHIP		0		9.00
10.00	Stand-alone SCHIP charges		0		10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)		0		11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		0		12.00
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0		13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0		14.00
15.00	State or local indigent care program cost (line 1 times line 14)		0		15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0		16.00
Uncompensated care (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0		17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		25,106		18.00
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		8,133,410		19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	7,217,800	33,427	7,251,227	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	1,923,970	8,910	1,932,880	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,923,970	8,910	1,932,880	23.00
				1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?				24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit			0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)			10,078,115	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)			189,340	27.00
28.00	Non-Medicare and Non-Reimbursable Medicare bad debt expense (line 26 minus line 27)			9,888,775	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)			2,635,942	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)			4,568,822	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			12,702,232	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150010

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

Worksheet A
Date/Time Prepared: 11/26/2013 6:05 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100		5,450,535	5,450,535	1,981,824	7,432,359	1.00
2.00	00200		0	0	0	0	2.00
4.00	00400		9,979,685	10,400,813	641,719	11,042,532	4.00
5.01	00510	421,128	263,378	263,378	-169,292	94,086	5.01
5.02	00511	0	50,847	275,531	-1,036	274,495	5.02
5.03	00512	224,684	340,744	666,030	39,432	705,462	5.03
5.04	00513	325,286	142,287	1,205,681	-11,543	1,194,138	5.04
5.05	00514	1,063,394	1,325,419	1,583,654	-14,399	1,569,255	5.05
5.06	00560	258,235	18,172,202	23,837,662	-1,007,381	22,830,281	5.06
7.00	00700	5,665,460	2,596,700	3,527,888	218,213	3,746,101	7.00
8.00	00800	931,188	0	0	478,421	478,421	8.00
9.00	00900	0	2,227,709	2,227,806	-413,912	1,813,894	9.00
10.00	01000	97	2,589,623	2,589,623	-1,851,293	738,330	10.00
11.00	01100	0	0	0	1,850,449	1,850,449	11.00
13.00	01300	0	79,899	439,731	-78,192	361,539	13.00
15.00	01500	359,832	3,834,268	5,314,996	-184,793	5,130,203	15.00
16.00	01600	1,480,728	100,724	953,818	-2,695	951,123	16.00
17.00	01700	853,094	106,296	525,491	-1,053	524,438	17.00
23.00	02300	419,195	14,029	80,446	94,160	174,606	23.00
66,417							
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	5,414,835	679,890	6,094,725	-430,465	5,664,260	30.00
31.00	03100	1,333,690	206,723	1,540,413	-144,021	1,396,392	31.00
41.00	04100	1,323,422	93,781	1,417,203	-49,895	1,367,308	41.00
43.00	04300	0	0	0	547,620	547,620	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	3,662,595	7,351,229	11,013,824	-4,353,333	6,660,491	50.00
51.00	05100	0	0	0	0	0	51.00
52.00	05200	2,053,740	432,632	2,486,372	-711,705	1,774,667	52.00
53.00	05300	0	71,956	71,956	-56,556	15,400	53.00
54.00	05400	3,331,404	2,034,933	5,366,337	-422,988	4,943,349	54.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	131,930	381,035	512,965	-120,354	392,611	59.00
60.00	06000	0	6,056,833	6,056,833	-6,754	6,050,079	60.00
65.00	06500	1,448,537	237,314	1,685,851	-32,177	1,653,674	65.00
66.00	06600	2,618,049	757,635	3,375,684	-433,654	2,942,030	66.00
69.00	06900	1,139,187	474,062	1,613,249	-243,037	1,370,212	69.00
71.00	07100	349,851	1,183,211	1,533,062	1,788,354	3,321,416	71.00
72.00	07200	0	0	0	3,820,323	3,820,323	72.00
73.00	07300	0	0	0	237,101	237,101	73.00
74.00	07400	0	159,958	159,958	-3,758	156,200	74.00
76.00	03020	789,012	436,100	1,225,112	-48,044	1,177,068	76.00
76.02	03022	366,118	342,344	708,462	-76,673	631,789	76.02
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	170,489	503,634	674,123	-36,092	638,031	90.00
91.00	09100	1,774,690	1,017,385	2,792,075	-150,785	2,641,290	91.00
92.00	09200						92.00
92.01	09201	0	0	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	847,190	129,353	976,543	-28,992	947,551	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300		584,173	584,173	-584,173	0	113.00
118.00		38,823,477	70,408,526	109,232,003	28,571	109,260,574	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	238,509	80,560	319,069	-28,571	290,498	194.01
194.04	07952	0	0	0	0	0	194.04
200.00		39,061,986	70,489,086	109,551,072	0	109,551,072	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150010

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

Worksheet A
Date/Time Prepared:
11/26/2013 6:05 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,090,807	8,523,166	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	0	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	377,584	11,420,116	4.00
5.01	00510	NONPATIENT TELEPHONES	451,320	545,406	5.01
5.02	00511	DATA PROCESSING	4,472,401	4,746,896	5.02
5.03	00512	PURCHASING, RECEIVING AND STORES	500,736	1,206,198	5.03
5.04	00513	ADMINISTRATIVE	0	1,194,138	5.04
5.05	00514	CASHIERING/ACCOUNTS RECEIVABLE	478,242	2,047,497	5.05
5.06	00560	OTHER ADMINISTRATIVE AND GENERAL	-13,252,868	9,577,413	5.06
7.00	00700	OPERATION OF PLANT	-4,521	3,741,580	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-44,036	434,385	8.00
9.00	00900	HOUSEKEEPING	0	1,813,894	9.00
10.00	01000	DIETARY	-52,825	685,505	10.00
11.00	01100	CAFETERIA	-585,857	1,264,592	11.00
13.00	01300	NURSING ADMINISTRATION	0	361,539	13.00
15.00	01500	PHARMACY	-30,117	5,100,086	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	531,894	1,483,017	16.00
17.00	01700	SOCIAL SERVICE	0	524,438	17.00
23.00	02300	ALLIED HEALTH	0	174,606	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-18,810	5,645,450	30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,396,392	31.00
41.00	04100	SUBPROVIDER - I RF	0	1,367,308	41.00
43.00	04300	NURSERY	-676	546,944	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	6,660,491	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-163	1,774,504	52.00
53.00	05300	ANESTHESIOLOGY	0	15,400	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-258,797	4,684,552	54.00
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	392,611	59.00
60.00	06000	LABORATORY	-5,377	6,044,702	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,653,674	65.00
66.00	06600	PHYSICAL THERAPY	-44,981	2,897,049	66.00
69.00	06900	ELECTROCARDIOLOGY	-5,496	1,364,716	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,321,416	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,820,323	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	237,101	73.00
74.00	07400	RENAL DIALYSIS	0	156,200	74.00
76.00	03020	PSYCH SERVICES	-289,906	887,162	76.00
76.02	03022	ENDOSCOPY	0	631,789	76.02
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	638,031	90.00
91.00	09100	EMERGENCY	0	2,641,290	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	92.01
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	947,551	95.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-6,691,446	102,569,128	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
194.00	07950	FOUNDATION	0	0	194.00
194.01	07951	CLINIC OF HOPE	0	290,498	194.01
194.04	07952	COMMUNITY RELATIONS	1,238,174	1,238,174	194.04
200.00		TOTAL (SUM OF LINES 118-199)	-5,453,272	104,097,800	200.00

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - BENEFITS TRANSFER					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	641,719	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
TOTALS			0	641,719	
B - UTILITIES TRANSFER					
1.00	OPERATION OF PLANT	7.00	0	220,125	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
TOTALS			0	220,125	
C - PHARMACY - CHARGEABLE DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	237,101	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
TOTALS			0	237,101	
D - BUILDING RENT					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	700,006	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
TOTALS			0	700,006	
E - RENT-LEASE EQUIPMENT					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	472,834	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00

RECLASSIFICATIONS

Provider CCN: 150010

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

Worksheet A-6
Date/Time Prepared:
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		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
29.00		0.00	0	0	29.00
TOTALS					
					472,834
F - TAXES					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	80,788	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
TOTALS					
					80,788
G - LAUNDRY					
1.00	LAUNDRY & LINEN SERVICE	8.00	0	478,421	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
TOTALS					
					478,421
H - INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	144,023	1.00
TOTALS					
					144,023
I - NURSERY					
1.00	NURSERY	43.00	429,240	118,380	1.00
TOTALS					
					429,240
					118,380
J - INTEREST					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	584,173	1.00
TOTALS					
					584,173
L - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	1,837,130	1.00
2.00	PURCHASING, RECEIVING AND STORES	5.03	0	70,079	2.00
3.00	LABORATORY	60.00	0	7,068	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
TOTALS					
					1,914,277
N - CHARITABLE EXPENSES					
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	6,230	1.00
TOTALS					
					6,230
O - DIETARY-CAFETERIA					
1.00	CAFETERIA	11.00	0	1,850,449	1.00
TOTALS					
					1,850,449
P - IMPLANTABLES					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	3,820,323	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
TOTALS					
					3,820,323

RECLASSIFICATIONS

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Period:
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To 06/30/2013

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		Increases				
Cost Center		Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
Q - PARAMED						
1.00	ALLIED HEALTH	23.00	94,160	0	1.00	
	TOTALS		94,160	0		
500.00	Grand Total: Increases		523,400	11,268,849	500.00	

RECLASSIFICATIONS

Provider CCN: 150010

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

Worksheet A-6
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Decreases						Wkst. A-7 Ref.	
Cost Center	Line #	Salary	Other				
6.00	7.00	8.00	9.00	10.00			
A - BENEFITS TRANSFER							
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	640,134	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	828	0		2.00
3.00	OPERATING ROOM	50.00	0	94	0		3.00
4.00	PHYSICAL THERAPY	66.00	0	663	0		4.00
	TOTALS		0	641,719			
B - UTILITIES TRANSFER							
1.00	NONPATIENT TELEPHONES	5.01	0	138,170	0		1.00
2.00	ADMINISTRATIVE	5.04	0	180	0		2.00
3.00	CASHIERING/ACCOUNTS RECEIVABLE	5.05	0	11,777	0		3.00
4.00	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	12,539	0		4.00
5.00	MEDICAL RECORDS & LIBRARY	16.00	0	39	0		5.00
6.00	SUBPROVIDER - IRF	41.00	0	140	0		6.00
7.00	OPERATING ROOM	50.00	0	890	0		7.00
8.00	DELIVERY ROOM & LABOR ROOM	52.00	0	604	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	13,804	0		9.00
10.00	LABORATORY	60.00	0	446	0		10.00
11.00	RESPIRATORY THERAPY	65.00	0	16	0		11.00
12.00	PHYSICAL THERAPY	66.00	0	32,340	0		12.00
13.00	ELECTROCARDIOLOGY	69.00	0	9,180	0		13.00
	TOTALS		0	220,125			
C - PHARMACY - CHARGEABLE DRUGS							
1.00	PURCHASING, RECEIVING AND STORES	5.03	0	1,298	0		1.00
2.00	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	7,055	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	912	0		3.00
4.00	INTENSIVE CARE UNIT	31.00	0	143	0		4.00
5.00	SUBPROVIDER - IRF	41.00	0	55	0		5.00
6.00	OPERATING ROOM	50.00	0	2,480	0		6.00
7.00	DELIVERY ROOM & LABOR ROOM	52.00	0	205	0		7.00
8.00	ANESTHESIOLOGY	53.00	0	56,140	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	80,253	0		9.00
10.00	LABORATORY	60.00	0	88	0		10.00
11.00	RESPIRATORY THERAPY	65.00	0	1,080	0		11.00
12.00	PHYSICAL THERAPY	66.00	0	1,081	0		12.00
13.00	ELECTROCARDIOLOGY	69.00	0	64,314	0		13.00
14.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	471	0		14.00
15.00	RENAL DIALYSIS	74.00	0	227	0		15.00
16.00	ENDOSCOPY	76.02	0	26	0		16.00
17.00	CLINIC	90.00	0	3,513	0		17.00
18.00	EMERGENCY	91.00	0	506	0		18.00
19.00	AMBULANCE SERVICES	95.00	0	5,511	0		19.00
20.00	CLINIC OF HOPE	194.01	0	11,743	0		20.00
	TOTALS		0	237,101			
D - BUILDING RENT							
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	120,284	9		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	42,201	0		2.00
3.00	LABORATORY	60.00	0	6,151	0		3.00
4.00	PHYSICAL THERAPY	66.00	0	344,040	0		4.00
5.00	ELECTROCARDIOLOGY	69.00	0	121,416	0		5.00
6.00	PSYCH SERVICES	76.00	0	47,774	0		6.00
7.00	CLINIC	90.00	0	3,140	0		7.00
8.00	CLINIC OF HOPE	194.01	0	15,000	0		8.00
	TOTALS		0	700,006			
E - RENT-LEASE EQUIPMENT							
1.00	NONPATIENT TELEPHONES	5.01	0	31,122	9		1.00
2.00	DATA PROCESSING	5.02	0	1,036	0		2.00
3.00	PURCHASING, RECEIVING AND STORES	5.03	0	29,349	0		3.00
4.00	ADMINISTRATIVE	5.04	0	3,962	0		4.00
5.00	CASHIERING/ACCOUNTS RECEIVABLE	5.05	0	2,582	0		5.00
6.00	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	8,754	0		6.00
7.00	OPERATION OF PLANT	7.00	0	1,814	0		7.00
8.00	HOUSEKEEPING	9.00	0	407	0		8.00
9.00	DIETARY	10.00	0	412	0		9.00
10.00	NURSING ADMINISTRATION	13.00	0	70,280	0		10.00

RECLASSIFICATIONS

Provider CCN: 150010

Period:
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Decreases								
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.			
	6.00	7.00	8.00	9.00	10.00			
11.00	PHARMACY	15.00	0	179,919	0		11.00	
12.00	MEDICAL RECORDS & LIBRARY	16.00	0	2,656	0		12.00	
13.00	SOCIAL SERVICE	17.00	0	1,053	0		13.00	
14.00	ADULTS & PEDIATRICS	30.00	0	8,323	0		14.00	
15.00	INTENSIVE CARE UNIT	31.00	0	383	0		15.00	
16.00	SUBPROVIDER - IRF	41.00	0	1,037	0		16.00	
17.00	OPERATING ROOM	50.00	0	3,317	0		17.00	
18.00	DELIVERY ROOM & LABOR ROOM	52.00	0	1,852	0		18.00	
19.00	RADIOLOGY-DIAGNOSTIC	54.00	0	63,041	0		19.00	
20.00	LABORATORY	60.00	0	508	0		20.00	
21.00	RESPIRATORY THERAPY	65.00	0	16,130	0		21.00	
22.00	PHYSICAL THERAPY	66.00	0	16,082	0		22.00	
23.00	ELECTROCARDIOLOGY	69.00	0	3,472	0		23.00	
24.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	18,636	0		24.00	
25.00	PSYCH SERVICES	76.00	0	25	0		25.00	
26.00	CLINIC	90.00	0	408	0		26.00	
27.00	EMERGENCY	91.00	0	4,831	0		27.00	
28.00	AMBULANCE SERVICES	95.00	0	408	0		28.00	
29.00	CLINIC OF HOPE	194.01	0	1,035	0		29.00	
	TOTALS		0	472,834				
F - TAXES								
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	79,591	9		1.00	
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	798	0		2.00	
3.00	LABORATORY	60.00	0	399	0		3.00	
	TOTALS		0	80,788				
G - LAUNDRY								
1.00	HOUSEKEEPING	9.00	0	412,715	0		1.00	
2.00	OPERATING ROOM	50.00	0	33,935	0		2.00	
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,525	0		3.00	
4.00	PHYSICAL THERAPY	66.00	0	19,174	0		4.00	
5.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	10,072	0		5.00	
	TOTALS		0	478,421				
H - INSURANCE								
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	144,023	9		1.00	
	TOTALS		0	144,023				
I - NURSERY								
1.00	DELIVERY ROOM & LABOR ROOM	52.00	429,240	118,380	0		1.00	
	TOTALS		429,240	118,380				
J - INTEREST								
1.00	INTEREST EXPENSE	113.00	0	584,173	9		1.00	
	TOTALS		0	584,173				
L - MEDICAL SUPPLIES								
1.00	ADMINISTRATIVE	5.04	0	7,401	0		1.00	
2.00	CASHIERING/ACCOUNTS RECEIVABLE	5.05	0	40	0		2.00	
3.00	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	1,231	0		3.00	
4.00	OPERATION OF PLANT	7.00	0	98	0		4.00	
5.00	HOUSEKEEPING	9.00	0	790	0		5.00	
6.00	DIETARY	10.00	0	432	0		6.00	
7.00	NURSING ADMINISTRATION	13.00	0	7,912	0		7.00	
8.00	PHARMACY	15.00	0	4,874	0		8.00	
9.00	ADULTS & PEDIATRICS	30.00	0	420,402	0		9.00	
10.00	INTENSIVE CARE UNIT	31.00	0	143,495	0		10.00	
11.00	SUBPROVIDER - IRF	41.00	0	48,663	0		11.00	
12.00	OPERATING ROOM	50.00	0	538,482	0		12.00	
13.00	DELIVERY ROOM & LABOR ROOM	52.00	0	161,424	0		13.00	
14.00	ANESTHESIOLOGY	53.00	0	416	0		14.00	
15.00	RADIOLOGY-DIAGNOSTIC	54.00	0	126,206	0		15.00	
16.00	CARDIAC CATHETERIZATION	59.00	0	93,763	0		16.00	
17.00	RESPIRATORY THERAPY	65.00	0	14,951	0		17.00	
18.00	PHYSICAL THERAPY	66.00	0	20,274	0		18.00	
19.00	ELECTROCARDIOLOGY	69.00	0	44,655	0		19.00	
20.00	RENAL DIALYSIS	74.00	0	3,531	0		20.00	
21.00	PSYCH SERVICES	76.00	0	245	0		21.00	
22.00	ENDOSCOPY	76.02	0	76,647	0		22.00	
23.00	CLINIC	90.00	0	29,031	0		23.00	
24.00	EMERGENCY	91.00	0	145,448	0		24.00	
25.00	AMBULANCE SERVICES	95.00	0	23,073	0		25.00	
26.00	CLINIC OF HOPE	194.01	0	793	0		26.00	

RECLASSIFICATIONS

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Period:
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Worksheet A-6

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		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	TOTALS		0	1,914,277			
	N - CHARITABLE EXPENSES						
1.00	LABORATORY	60.00	0	6,230	0		1.00
	TOTALS		0	6,230			
	O - DIETARY-CAFETERIA						
1.00	DIETARY	10.00	0	1,850,449	0		1.00
	TOTALS		0	1,850,449			
	P - IMPLANTABLES						
1.00	OPERATING ROOM	50.00	0	3,774,135	0		1.00
2.00	CARDIAC CATHETERIZATION	59.00	0	26,591	0		2.00
3.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	19,597	0		3.00
	TOTALS		0	3,820,323			
	Q - PARAMED						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	94,160	0	0		1.00
	TOTALS		94,160	0			
500.00	Grand Total: Decreases		523,400	11,268,849			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150010

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

Worksheet A-7
Part I
Date/Time Prepared:
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	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,422,671	0	0	699,892	1.00
2.00	Land Improvements	2,293,922	0	0	0	2.00
3.00	Buildings and Fixtures	55,924,815	0	0	0	3.00
4.00	Building Improvements	8,894,843	618,905	0	844	4.00
5.00	Fixed Equipment	23,888,554	801,607	0	2,615	5.00
6.00	Movable Equipment	45,287,534	2,861,817	0	2,021,537	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	137,712,339	4,282,329	0	2,724,888	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	137,712,339	4,282,329	0	2,724,888	10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	722,779	0			1.00
2.00	Land Improvements	2,293,922	0			2.00
3.00	Buildings and Fixtures	55,924,815	0			3.00
4.00	Building Improvements	9,512,904	0			4.00
5.00	Fixed Equipment	24,687,546	0			5.00
6.00	Movable Equipment	46,127,814	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	139,269,780	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	139,269,780	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150010

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

Worksheet A-7
Part II
Date/Time Prepared:
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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	5,316,356	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	5,316,356	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	134,179	5,450,535				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	134,179	5,450,535				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150010

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

Worksheet A-7
Part III
Date/Time Prepared:
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Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL			
	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance		
	1.00	2.00	3.00	4.00	5.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	93,141,966	0	93,141,966	0.668788	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	46,127,814	0	46,127,814	0.331212	0	2.00
3.00	Total (sum of lines 1-2)	139,269,780	0	139,269,780	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	8,388,987	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	8,388,987	0	3.00
Cost Center Description	SUMMARY OF CAPITAL						
	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)		
	11.00	12.00	13.00	14.00	15.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	134,179	8,523,166	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	134,179	8,523,166	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 150010

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

Worksheet A-8

Date/Time Prepared:
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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				
			Cost Center		Line #	Wkst. A-7 Ref.	
			1.00	2.00	3.00	4.00	5.00
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00 Investment income - other (chapter 2)			0		0.00	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)	B	-320	0	NONPATIENT TELEPHONES	5.01	0	7.00
8.00 Television and radio service (chapter 21)	A	-3,139	0	OPERATION OF PLANT	7.00	0	8.00
9.00 Parking lot (chapter 21)			0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-1,282,861	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	4,038,044	0			0	12.00
13.00 Laundry and linen service			0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-578,850	0	CAFETERIA	11.00	0	14.00
15.00 Rental of quarters to employee and others			0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients			0		0.00	0	16.00
17.00 Sale of drugs to other than patients			0		0.00	0	17.00
18.00 Sale of medical records and abstracts			0		0.00	0	18.00
19.00 Nursing school (tuition, fees, books, etc.)			0		0.00	0	19.00
20.00 Vending machines			0		0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0	RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0	PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0	*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT			0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00 Non-physician Anesthetist			0	*** Cost Center Deleted ***	19.00		28.00
29.00 Physicians' assistant			0		0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	*** Cost Center Deleted ***	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)			0	ADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	*** Cost Center Deleted ***	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest			0		0.00	0	32.00
33.00 SOUTHWAY REHAB OTH OP REV	B	-10,804	0	PHYSICAL THERAPY	66.00	0	33.00
34.00 FOREST PARK REHAB OTH OP REV	B	-34,177	0	PHYSICAL THERAPY	66.00	0	34.00

Provider CCN: 150010

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

Worksheet A-8

Date/Time Prepared:
 11/26/2013 6:05 pm

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		
35.00 INFORMATION SERVICES OTHER OP REV	B	-7,750	DATA PROCESSING	5.02	0	35.00
36.00 HOSPITAL ASSESSMENT FEE	A	-6,872,105	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	36.00
37.00 ORGANIZATIONAL LEARNING OTHER OP REV	B	-1,566	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	37.00
38.00 RENTAL INCOME	B	-442,873	CAP REL COSTS-BLDG & FIXT	1.00	9	38.00
39.00		0		0.00	0	39.00
41.00 PLANT OPERATIONS OTHER OP REV	B	-1,382	OPERATION OF PLANT	7.00	0	41.00
42.00 PATIENT TELEVISION	A	-7,414	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	42.00
43.00 FOOD SERVICES OTHER OP REV	B	-52,825	DIETARY	10.00	0	43.00
44.00 TRINITY OTHER OP REV	B	-2,310	ADULTS & PEDIATRICS	30.00	0	44.00
44.01 NURSERY OTHER OP REV	B	-676	NURSERY	43.00	0	44.01
44.02 SLEEP LAB OTHER OP REV	B	-5,496	ELECTROCARDIOLOGY	69.00	0	44.02
45.00 SUPPLY CHAIN OTHER OP REV	B	-49	PURCHASING, RECEIVING AND STORES	5.03	0	45.00
45.02 1994 AHA LIVES	A	12,652	CAP REL COSTS-BLDG & FIXT	1.00	9	45.02
45.05 RADIATION OTHER OP REV	B	-112,729	RADIOLOGY-DIAGNOSTIC	54.00	0	45.05
45.08 LABORATORY OTHER OP REV	B	-5,377	LABORATORY	60.00	0	45.08
45.12 LOBBY EXPENSE	A	-2,664	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	45.12
45.13 LABOR & DELIVERY OTHER OP REV	B	-163	DELIVERY ROOM & LABOR ROOM	52.00	0	45.13
45.15 OTHER OP REV	B	-2,389	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	45.15
45.18 PHARMACY NON-PATIENT SALES	B	-30,117	PHARMACY	15.00	0	45.18
45.19 WOMENS HEALTH OTHER OP REV	B	-25,514	RADIOLOGY-DIAGNOSTIC	54.00	0	45.19
45.20 SYCAMORE PRIMARY CARE	B	-12,341	CAP REL COSTS-BLDG & FIXT	1.00	9	45.20
45.23 CAFETERIA/VENDING REVENUE	B	-7,007	CAFETERIA	11.00	0	45.23
45.24 HR OTHER OP REV	B	-220	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	45.24
45.25 HIM ADMIN OTHER OP REV	B	-765	MEDICAL RECORDS & LIBRARY	16.00	0	45.25
45.26 FINANCIAL SVCS OTHER OP REV	B	-85	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	45.26
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-5,453,272				50.00

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

Provider CCN: 150010

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

Worksheet A-8-1

Date/Time Prepared: 11/26/2013 6:05 pm

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	NCI LINEN	203,620	0
2.00	8.00	LAUNDRY & LINEN SERVICE	NCI LINEN	368,544	412,580
3.00	1.00	CAP REL COSTS-BLDG & FIXT	TRIMEDX CAPITAL	14,316	14,112
4.00	5.06	OTHER ADMINISTRATIVE AND GENERAL	TRIMEDX OTHER	1,634,964	1,611,684
4.01	1.00	CAP REL COSTS-BLDG & FIXT	SVH CAPITAL	1,543,484	0
4.02	4.00	EMPLOYEE BENEFITS DEPARTMENT	SVH PENSION	1,191,333	1,438,209
4.03	5.06	OTHER ADMINISTRATIVE AND GENERAL	SVH A&G - SALARIES	1,714,043	1,845,516
4.10	1.00	CAP REL COSTS-BLDG & FIXT	ASCENSION HEALTH-INTEREST	294,631	508,570
4.11	5.06	OTHER ADMINISTRATIVE AND GENERAL	ASCENSION HEALTH-INTEREST	43,760	75,535
4.12	0.00		ASCENSION HEALTH-SERVICE FEE	0	0
4.14	194.04	COMMUNITY RELATIONS	SVH MARKETING-SALARIES	275,739	0
4.15	194.04	COMMUNITY RELATIONS	SVH MARKETING - OTHER	962,435	0
4.16	5.06	OTHER ADMINISTRATIVE AND GENERAL	SVH A&G - OTHER	1,828,264	7,198,820
4.17	4.00	EMPLOYEE BENEFITS DEPARTMENT	SVH - EMP BENEFITS - SALARIES	203,632	0
4.18	4.00	EMPLOYEE BENEFITS DEPARTMENT	SVH - EMP BENEFITS - OTHER	1,313,039	0
4.19	5.01	NONPATIENT TELEPHONES	SVH - PHONES - SALARIES	97,239	0
4.20	5.01	NONPATIENT TELEPHONES	SVH - PHONES - OTHER	354,401	0
4.21	5.02	DATA PROCESSING	SVH IT - SALARIES	1,670,861	0
4.22	5.02	DATA PROCESSING	SVH IT - OTHER	2,809,290	0
4.23	5.03	PURCHASING, RECEIVING AND STORES	SVH - PURCHASING - SALARIES	282,542	0
4.24	5.03	PURCHASING, RECEIVING AND STORES	SVH - PURCHASING - OTHER	218,243	0
4.25	0.00		SVH - ADMINITTING - SALARIES	0	0
4.26	0.00		SVH - ADMINITTING - OTHER	0	0
4.27	5.05	CASHIERING/ACCOUNTS RECEIVABLE	SVH - CASHIER - SALARIES	312,801	0
4.28	5.05	CASHIERING/ACCOUNTS RECEIVABLE	SVH - CASHIER - OTHER	165,441	0
4.33	16.00	MEDICAL RECORDS & LIBRARY	SVH - MEDICAL RECS - SALARIES	380,147	0
4.34	16.00	MEDICAL RECORDS & LIBRARY	SVH - MEDICAL RECS - OTHER	152,512	0
4.45	4.00	EMPLOYEE BENEFITS DEPARTMENT	STV SELF INSURANCE	5,710,358	6,602,569
5.00	0		0	23,745,639	19,707,595

* 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	C	0.00	NCI L	0.00	6.00
7.00	B	0.00	ST VINCENT HEAL	100.00	7.00
8.00	B	0.00	ASCENSION HEALT	100.00	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:				100.00

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

Provider CCN: 150010

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

Worksheet A-8-1

Date/Time Prepared:
11/26/2013 6:05 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: 150010

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

Worksheet A-8-1

Date/Time Prepared:
11/26/2013 6:05 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	203,620	9		1.00
2.00	-44,036	0		2.00
3.00	204	9		3.00
4.00	23,280	0		4.00
4.01	1,543,484	9		4.01
4.02	-246,876	0		4.02
4.03	-131,473	0		4.03
4.10	-213,939	9		4.10
4.11	-31,775	0		4.11
4.12	0	0		4.12
4.14	275,739	0		4.14
4.15	962,435	0		4.15
4.16	-5,370,556	0		4.16
4.17	203,632	0		4.17
4.18	1,313,039	0		4.18
4.19	97,239	0		4.19
4.20	354,401	0		4.20
4.21	1,670,861	0		4.21
4.22	2,809,290	0		4.22
4.23	282,542	0		4.23
4.24	218,243	0		4.24
4.25	0	0		4.25
4.26	0	0		4.26
4.27	312,801	0		4.27
4.28	165,441	0		4.28
4.33	380,147	0		4.33
4.34	152,512	0		4.34
4.45	-892,211	0		4.45
5.00	4,038,044			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	LAUNDRY FACILITY		6.00
7.00	HOSPITAL MGMT		7.00
8.00	HOSPITAL MGMT		8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 150010

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

Worksheet A-8-2

Date/Time Prepared: 11/26/2013 6:05 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	54.00	RADIOLOGY-DIAGNOSTIC	494	494	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	18,849	18,849	0	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	55,000	55,000	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	46,211	46,211	0	0	0	4.00
5.00	30.00	ADULTS & PEDIATRICS	16,500	16,500	0	0	0	5.00
6.00	76.00	PSYCH SERVICES	102,689	102,689	0	0	0	6.00
7.00	76.00	PSYCH SERVICES	187,217	187,217	0	0	0	7.00
8.00	5.06	OTHER ADMINISTRATIVE AND GENERAL	132,300	132,300	0	0	0	8.00
9.00	5.06	OTHER ADMINISTRATIVE AND GENERAL	157,300	157,300	0	0	0	9.00
10.00	5.06	OTHER ADMINISTRATIVE AND GENERAL	191,000	191,000	0	0	0	10.00
11.00	5.06	OTHER ADMINISTRATIVE AND GENERAL	1,620	1,620	0	0	0	11.00
12.00	5.06	OTHER ADMINISTRATIVE AND GENERAL	168,000	168,000	0	0	0	12.00
13.00	5.06	OTHER ADMINISTRATIVE AND GENERAL	93,000	93,000	0	0	0	13.00
14.00	5.06	OTHER ADMINISTRATIVE AND GENERAL	200	200	0	0	0	14.00
15.00	5.06	OTHER ADMINISTRATIVE AND GENERAL	20,000	20,000	0	0	0	15.00
16.00	5.06	OTHER ADMINISTRATIVE AND GENERAL	12,481	12,481	0	0	0	16.00
17.00	5.06	OTHER ADMINISTRATIVE AND GENERAL	80,000	80,000	0	0	0	17.00
200.00			1,282,861	1,282,861	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	4.00
5.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	5.00
6.00	76.00	PSYCH SERVICES	0	0	0	0	0	6.00
7.00	76.00	PSYCH SERVICES	0	0	0	0	0	7.00
8.00	5.06	OTHER ADMINISTRATIVE AND GENERAL	0	0	0	0	0	8.00
9.00	5.06	OTHER ADMINISTRATIVE AND GENERAL	0	0	0	0	0	9.00
10.00	5.06	OTHER ADMINISTRATIVE AND GENERAL	0	0	0	0	0	10.00
11.00	5.06	OTHER ADMINISTRATIVE AND GENERAL	0	0	0	0	0	11.00
12.00	5.06	OTHER ADMINISTRATIVE AND GENERAL	0	0	0	0	0	12.00
13.00	5.06	OTHER ADMINISTRATIVE AND GENERAL	0	0	0	0	0	13.00
14.00	5.06	OTHER ADMINISTRATIVE AND GENERAL	0	0	0	0	0	14.00
15.00	5.06	OTHER ADMINISTRATIVE AND GENERAL	0	0	0	0	0	15.00
16.00	5.06	OTHER ADMINISTRATIVE AND GENERAL	0	0	0	0	0	16.00
17.00	5.06	OTHER ADMINISTRATIVE AND GENERAL	0	0	0	0	0	17.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	494		1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	18,849		2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	55,000		3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	46,211		4.00
5.00	30.00	ADULTS & PEDIATRICS	0	0	0	16,500		5.00
6.00	76.00	PSYCH SERVICES	0	0	0	102,689		6.00
7.00	76.00	PSYCH SERVICES	0	0	0	187,217		7.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 150010

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

Worksheet A-8-2
Date/Time Prepared:
11/26/2013 6:05 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
8.00	5.06	OTHER ADMINISTRATIVE AND GENERAL	0	0	0	132,300		8.00
9.00	5.06	OTHER ADMINISTRATIVE AND GENERAL	0	0	0	157,300		9.00
10.00	5.06	OTHER ADMINISTRATIVE AND GENERAL	0	0	0	191,000		10.00
11.00	5.06	OTHER ADMINISTRATIVE AND GENERAL	0	0	0	1,620		11.00
12.00	5.06	OTHER ADMINISTRATIVE AND GENERAL	0	0	0	168,000		12.00
13.00	5.06	OTHER ADMINISTRATIVE AND GENERAL	0	0	0	93,000		13.00
14.00	5.06	OTHER ADMINISTRATIVE AND GENERAL	0	0	0	200		14.00
15.00	5.06	OTHER ADMINISTRATIVE AND GENERAL	0	0	0	20,000		15.00
16.00	5.06	OTHER ADMINISTRATIVE AND GENERAL	0	0	0	12,481		16.00
17.00	5.06	OTHER ADMINISTRATIVE AND GENERAL	0	0	0	80,000		17.00
200.00			0	0	0	1,282,861		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150010

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

Worksheet B
Part I
Date/Time Prepared:
11/26/2013 6:05 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONES	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	5.01	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	8,523,166	8,523,166			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	0		0		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	11,420,116	334,665	0	11,754,781	4.00
5.01 00510	NONPATIENT TELEPHONES	545,406	8,354	0	0	553,760 5.01
5.02 00511	DATA PROCESSING	4,746,896	86,825	0	68,350	27,190 5.02
5.03 00512	PURCHASING, RECEIVING AND STORES	1,206,198	106,717	0	98,954	13,595 5.03
5.04 00513	ADMINISTRATIVE	1,194,138	42,916	0	323,491	10,876 5.04
5.05 00514	CASHIERING/ACCOUNTS RECEIVABLE	2,047,497	49,182	0	78,557	12,688 5.05
5.06 00560	OTHER ADMINISTRATIVE AND GENERAL	9,577,413	1,014,201	0	1,723,467	73,410 5.06
7.00 00700	OPERATION OF PLANT	3,741,580	1,200,561	0	283,273	10,876 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	434,385	13,522	0	0	906 8.00
9.00 00900	HOUSEKEEPING	1,813,894	52,601	0	30	4,532 9.00
10.00 01000	DIETARY	685,505	135,876	0	0	19,939 10.00
11.00 01100	CAFETERIA	1,264,592	164,722	0	0	4,532 11.00
13.00 01300	NURSING ADMINISTRATION	361,539	68,551	0	109,463	14,501 13.00
15.00 01500	PHARMACY	5,100,086	83,510	0	450,446	13,595 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	1,483,017	63,879	0	259,516	14,501 16.00
17.00 01700	SOCIAL SERVICE	524,438	74,007	0	127,522	9,969 17.00
23.00 02300	ALLIED HEALTH	174,606	23,390	0	48,848	0 23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	5,645,450	768,632	0	1,647,225	36,253 30.00
31.00 03100	INTENSIVE CARE UNIT	1,396,392	147,127	0	405,717	27,190 31.00
41.00 04100	SUBPROVIDER - IRF	1,367,308	354,191	0	402,593	18,126 41.00
43.00 04300	NURSERY	546,944	42,003	0	130,577	9,063 43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	6,660,491	877,568	0	1,114,183	18,126 50.00
51.00 05100	RECOVERY ROOM	0	0	0	0	0 51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	1,774,504	85,206	0	494,183	27,190 52.00
53.00 05300	ANESTHESIOLOGY	15,400	7,231	0	0	19,033 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	4,684,552	674,054	0	984,789	32,627 54.00
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	392,611	10,442	0	40,134	6,344 59.00
60.00 06000	LABORATORY	6,044,702	206,229	0	0	5,438 60.00
65.00 06500	RESPIRATORY THERAPY	1,653,674	32,292	0	440,654	13,595 65.00
66.00 06600	PHYSICAL THERAPY	2,897,049	296,317	0	796,426	38,972 66.00
69.00 06900	ELECTROCARDIOLOGY	1,364,716	175,712	0	346,548	15,407 69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,321,416	112,486	0	106,427	1,813 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	3,820,323	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	237,101	0	0	0	0 73.00
74.00 07400	RENAL DIALYSIS	156,200	0	0	0	0 74.00
76.00 03020	PSYCH SERVICES	887,162	119,848	0	240,022	17,220 76.00
76.02 03022	ENDOSCOPY	631,789	0	0	111,375	0 76.02
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	638,031	78,315	0	51,864	906 90.00
91.00 09100	EMERGENCY	2,641,290	504,868	0	539,871	27,190 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					
92.01 09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0 92.01
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	947,551	103,584	0	257,720	1,813 95.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					
118.00	SUBTOTALS (SUM OF LINES 1-117)	102,569,128	8,119,584	0	11,682,225	547,416 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	26,862	0	0	906 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	376,720	0	0	2,719 192.00
194.00 07950	FOUNDATION	0	0	0	0	0 194.00
194.01 07951	CLINIC OF HOPE	290,498	0	0	72,556	2,719 194.01
194.04 07952	COMMUNITY RELATIONS	1,238,174	0	0	0	0 194.04
200.00	Cross Foot Adjustments					
201.00	Negative Cost Centers					
202.00	TOTAL (sum lines 118-201)	104,097,800	8,523,166	0	11,754,781	553,760 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150010

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

Worksheet B
Part I
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Cost Center Description			DATA PROCESSING	PURCHASING, RECEIVING AND STORES	ADMINITTING	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	
			5.02	5.03	5.04	5.05	5A.05	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00510	NONPATIENT TELEPHONES						5.01
5.02	00511	DATA PROCESSING	4,929,261					5.02
5.03	00512	PURCHASING, RECEIVING AND STORES	66,792	1,492,256				5.03
5.04	00513	ADMINITTING	133,584	7,341	1,712,346			5.04
5.05	00514	CASHIERING/ACCOUNTS RECEIVABLE	40,075	983	0	2,228,982		5.05
5.06	00560	OTHER ADMINISTRATIVE AND GENERAL	400,753	42,458	0	0	12,831,702	5.06
7.00	00700	OPERATION OF PLANT	80,151	1,589	0	0	5,318,030	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	448,813	8.00
9.00	00900	HOUSEKEEPING	40,075	2,929	0	0	1,914,061	9.00
10.00	01000	DIETARY	66,792	0	0	0	908,112	10.00
11.00	01100	CAFETERIA	0	0	0	0	1,433,846	11.00
13.00	01300	NURSING ADMINISTRATION	53,434	2,289	0	0	609,777	13.00
15.00	01500	PHARMACY	133,584	19,533	0	0	5,800,754	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	160,301	1,716	0	0	1,982,930	16.00
17.00	01700	SOCIAL SERVICE	66,792	567	0	0	803,295	17.00
23.00	02300	ALLIED HEALTH	0	0	0	0	246,844	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	280,527	133,339	110,058	143,254	8,764,738	30.00
31.00	03100	INTENSIVE CARE UNIT	467,545	41,675	25,966	33,798	2,545,410	31.00
41.00	04100	SUBPROVIDER - IIRF	146,943	16,455	24,051	31,306	2,360,973	41.00
43.00	04300	NURSERY	13,358	0	24,139	31,419	797,503	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	841,584	674,795	231,553	301,393	10,719,693	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	66,792	70,819	42,130	54,837	2,615,661	52.00
53.00	05300	ANESTHESIOLOGY	13,358	2,637	33,446	43,535	134,640	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	227,093	43,008	345,569	449,957	7,441,649	54.00
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	53,434	33,711	26,562	34,574	597,812	59.00
60.00	06000	LABORATORY	400,753	0	234,637	305,408	7,197,167	60.00
65.00	06500	RESPIRATORY THERAPY	53,434	6,493	45,459	59,170	2,304,771	65.00
66.00	06600	PHYSICAL THERAPY	320,602	11,177	87,890	114,399	4,562,832	66.00
69.00	06900	ELECTROCARDIOLOGY	0	19,578	70,958	92,360	2,085,279	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	212,538	45,236	58,880	3,858,796	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	71,705	93,333	3,985,361	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	52,059	67,761	356,921	73.00
74.00	07400	RENAL DIALYSIS	13,358	2,421	509	663	173,151	74.00
76.00	03020	PSYCH SERVICES	160,301	396	16,199	21,085	1,462,233	76.00
76.02	03022	ENDOSCOPY	0	76,361	37,659	49,017	906,201	76.02
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	53,434	8,900	24,441	31,813	887,704	90.00
91.00	09100	EMERGENCY	467,545	50,985	138,152	179,822	4,549,723	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	13,358	6,877	23,968	31,198	1,386,069	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,835,752	1,491,570	1,712,346	2,228,982	101,992,451	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	27,768	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	40,075	0	0	0	419,514	192.00
194.00	07950	FOUNDATION	0	0	0	0	0	194.00
194.01	07951	CLINIC OF HOPE	53,434	686	0	0	419,893	194.01
194.04	07952	COMMUNITY RELATIONS	0	0	0	0	1,238,174	194.04
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	4,929,261	1,492,256	1,712,346	2,228,982	104,097,800	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150010

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

Worksheet B
Part I
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Cost Center Description		OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.06	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00510						5.01
5.02	00511						5.02
5.03	00512						5.03
5.04	00513						5.04
5.05	00514						5.05
5.06	00560	12,831,702					5.06
7.00	00700		747,699	6,065,729			7.00
8.00	00800		63,102		526,356		8.00
9.00	00900		269,111	56,176		2,239,348	9.00
10.00	01000		127,678	145,110	9,898		10.00
11.00	01100		201,594	175,916			11.00
13.00	01300		85,733	73,210		2,223	13.00
15.00	01500		815,569	89,185			15.00
16.00	01600		278,794	68,220		3,334	16.00
17.00	01700		112,941	79,037		1,111	17.00
23.00	02300		34,706	24,980			23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	1,232,296	820,867	183,495	701,255	921,747	30.00
31.00	03100	357,877	157,126	23,872	166,701	39,760	31.00
41.00	04100	331,946	378,261	39,011	166,701	229,291	41.00
43.00	04300	112,127	44,857		33,340		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	1,507,116	937,205	95,119	333,402		50.00
51.00	05100						51.00
52.00	05200	367,754	90,997	50,709	283,391		52.00
53.00	05300	18,930	7,722		33,340		53.00
54.00	05400	1,046,274	719,862	33,611	67,792		54.00
57.00	05700						57.00
58.00	05800						58.00
59.00	05900	84,051	11,152	3,017	13,336		59.00
60.00	06000	1,011,900	220,243	339	68,903		60.00
65.00	06500	324,044	34,486		3,334		65.00
66.00	06600	641,520	316,454	3,493	16,670		66.00
69.00	06900	293,184	187,653	5,029	3,334		69.00
71.00	07100	542,535	120,130		62,235		71.00
72.00	07200	560,330					72.00
73.00	07300	50,182			26,672		73.00
74.00	07400	24,345			11,113		74.00
76.00	03020	205,586	127,992				76.00
76.02	03022	127,409					76.02
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	124,809	83,637		35,563		90.00
91.00	09100	639,677	539,178	74,317	205,598		91.00
92.00	09200						92.00
92.01	09201						92.01
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	194,877	110,624				95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		12,535,696	5,634,721	521,910	2,239,348	1,190,798	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	3,904	28,687				190.00
192.00	19200	58,982	402,321	4,446			192.00
194.00	07950						194.00
194.01	07951	59,036					194.01
194.04	07952	174,084					194.04
200.00							200.00
201.00							201.00
202.00		12,831,702	6,065,729	526,356	2,239,348	1,190,798	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150010

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

Worksheet B
Part I
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Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		11.00	13.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00510						5.01
5.02	00511						5.02
5.03	00512						5.03
5.04	00513						5.04
5.05	00514						5.05
5.06	00560						5.06
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	1,811,356					11.00
13.00	01300	15,991	786,934				13.00
15.00	01500	58,335	0	6,763,843			15.00
16.00	01600	74,019	0	0	2,407,297		16.00
17.00	01700	24,796	0	0	0	1,021,180	17.00
23.00	02300	8,966	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	360,567	174,155	0	154,702	690,168	30.00
31.00	03100	76,571	36,984	0	36,499	88,696	31.00
41.00	04100	89,016	42,995	0	33,807	170,500	41.00
43.00	04300	24,217	11,697	0	33,930	71,816	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	222,065	107,258	0	325,478	0	50.00
51.00	05100	0	0	0	0	0	51.00
52.00	05200	91,656	44,270	0	59,220	0	52.00
53.00	05300	0	0	0	47,014	0	53.00
54.00	05400	185,096	89,402	0	486,105	0	54.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	6,484	3,132	0	37,337	0	59.00
60.00	06000	0	0	0	329,813	0	60.00
65.00	06500	80,152	38,714	0	63,898	0	65.00
66.00	06600	137,647	66,484	0	123,541	0	66.00
69.00	06900	67,251	32,483	0	99,741	0	69.00
71.00	07100	32,728	15,808	0	63,586	0	71.00
72.00	07200	0	0	0	100,792	0	72.00
73.00	07300	0	0	6,763,843	73,176	0	73.00
74.00	07400	0	0	0	716	0	74.00
76.00	03020	39,919	19,281	0	22,770	0	76.00
76.02	03022	18,930	9,143	0	52,934	0	76.02
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	13,031	6,294	0	34,355	0	90.00
91.00	09100	93,300	45,064	0	194,192	0	91.00
92.00	09200						92.00
92.01	09201	0	0	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	75,676	36,552	0	33,691	0	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		1,796,413	779,716	6,763,843	2,407,297	1,021,180	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	14,943	7,218	0	0	0	194.01
194.04	07952	0	0	0	0	0	194.04
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		1,811,356	786,934	6,763,843	2,407,297	1,021,180	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150010

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

Worksheet B
Part I
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Cost Center Description			ALLIED HEALTH	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			23.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00510	NONPATIENT TELEPHONES					5.01
5.02	00511	DATA PROCESSING					5.02
5.03	00512	PURCHASING, RECEIVING AND STORES					5.03
5.04	00513	ADMITTING					5.04
5.05	00514	CASHIERING/ACCOUNTS RECEIVABLE					5.05
5.06	00560	OTHER ADMINISTRATIVE AND GENERAL					5.06
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
23.00	02300	ALLIED HEALTH	315,496				23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	14,003,990	0	14,003,990	30.00
31.00	03100	INTENSIVE CARE UNIT	0	3,529,496	0	3,529,496	31.00
41.00	04100	SUBPROVIDER - IIRF	0	3,842,501	0	3,842,501	41.00
43.00	04300	NURSERY	0	1,129,487	0	1,129,487	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	14,247,336	0	14,247,336	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,603,658	0	3,603,658	52.00
53.00	05300	ANESTHESIOLOGY	0	241,646	0	241,646	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	315,496	10,385,287	0	10,385,287	54.00
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	756,321	0	756,321	59.00
60.00	06000	LABORATORY	0	8,828,365	0	8,828,365	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,849,399	0	2,849,399	65.00
66.00	06600	PHYSICAL THERAPY	0	5,868,641	0	5,868,641	66.00
69.00	06900	ELECTROCARDIOLOGY	0	2,773,954	0	2,773,954	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,695,818	0	4,695,818	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	4,646,483	0	4,646,483	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,270,794	0	7,270,794	73.00
74.00	07400	RENAL DIALYSIS	0	209,325	0	209,325	74.00
76.00	03020	PSYCH SERVICES	0	1,877,781	0	1,877,781	76.00
76.02	03022	ENDOSCOPY	0	1,114,617	0	1,114,617	76.02
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	1,185,393	0	1,185,393	90.00
91.00	09100	EMERGENCY	0	6,341,049	0	6,341,049	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0		92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	1,837,489	0	1,837,489	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	315,496	101,238,830	0	101,238,830	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	60,359	0	60,359	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	885,263	0	885,263	192.00
194.00	07950	FOUNDATION	0	0	0	0	194.00
194.01	07951	CLINIC OF HOPE	0	501,090	0	501,090	194.01
194.04	07952	COMMUNITY RELATIONS	0	1,412,258	0	1,412,258	194.04
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)	315,496	104,097,800	0	104,097,800	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150010

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

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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			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	334,665	0	334,665	4.00
5.01 00510	NONPATIENT TELEPHONES	0	8,354	0	8,354	5.01
5.02 00511	DATA PROCESSING	0	86,825	0	86,825	5.02
5.03 00512	PURCHASING, RECEIVING AND STORES	0	106,717	0	106,717	5.03
5.04 00513	ADMITTING	0	42,916	0	42,916	5.04
5.05 00514	CASHIERING/ACCOUNTS RECEIVABLE	0	49,182	0	49,182	5.05
5.06 00560	OTHER ADMINISTRATIVE AND GENERAL	0	1,014,201	0	1,014,201	5.06
7.00 00700	OPERATION OF PLANT	0	1,200,561	0	1,200,561	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	13,522	0	13,522	8.00
9.00 00900	HOUSEKEEPING	0	52,601	0	52,601	9.00
10.00 01000	DIETARY	0	135,876	0	135,876	10.00
11.00 01100	CAFETERIA	0	164,722	0	164,722	11.00
13.00 01300	NURSING ADMINISTRATION	0	68,551	0	68,551	13.00
15.00 01500	PHARMACY	0	83,510	0	83,510	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	63,879	0	63,879	16.00
17.00 01700	SOCIAL SERVICE	0	74,007	0	74,007	17.00
23.00 02300	ALLIED HEALTH	0	23,390	0	23,390	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	768,632	0	768,632	30.00
31.00 03100	INTENSIVE CARE UNIT	0	147,127	0	147,127	31.00
41.00 04100	SUBPROVIDER - IRF	0	354,191	0	354,191	41.00
43.00 04300	NURSERY	0	42,003	0	42,003	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	877,568	0	877,568	50.00
51.00 05100	RECOVERY ROOM	0	0	0	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	85,206	0	85,206	52.00
53.00 05300	ANESTHESIOLOGY	0	7,231	0	7,231	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	674,054	0	674,054	54.00
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	10,442	0	10,442	59.00
60.00 06000	LABORATORY	0	206,229	0	206,229	60.00
65.00 06500	RESPIRATORY THERAPY	0	32,292	0	32,292	65.00
66.00 06600	PHYSICAL THERAPY	0	296,317	0	296,317	66.00
69.00 06900	ELECTROCARDIOLOGY	0	175,712	0	175,712	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	112,486	0	112,486	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
76.00 03020	PSYCH SERVICES	0	119,848	0	119,848	76.00
76.02 03022	ENDOSCOPY	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	78,315	0	78,315	90.00
91.00 09100	EMERGENCY	0	504,868	0	504,868	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
92.01 09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	0	103,584	0	103,584	95.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	8,119,584	0	8,119,584	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	26,862	0	26,862	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	376,720	0	376,720	192.00
194.00 07950	FOUNDATION	0	0	0	0	194.00
194.01 07951	CLINIC OF HOPE	0	0	0	0	194.01
194.04 07952	COMMUNITY RELATIONS	0	0	0	0	194.04
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	8,523,166	0	8,523,166	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150010

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From 07/01/2012
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Cost Center Description			NONPATIENT TELEPHONES	DATA PROCESSING	PURCHASING, RECEIVING AND STORES	ADMINISTRATIVE	CASHIERING/ACCOUNTS RECEIVABLE	
			5.01	5.02	5.03	5.04	5.05	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00510	NONPATIENT TELEPHONES	8,354					5.01
5.02	00511	DATA PROCESSING	410	89,181				5.02
5.03	00512	PURCHASING, RECEIVING AND STORES	205	1,208	110,947			5.03
5.04	00513	ADMINISTRATIVE	164	2,417	546	55,253		5.04
5.05	00514	CASHIERING/ACCOUNTS RECEIVABLE	191	725	73	0	52,408	5.05
5.06	00560	OTHER ADMINISTRATIVE AND GENERAL	1,110	7,250	3,157	0	0	5.06
7.00	00700	OPERATION OF PLANT	164	1,450	118	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	14	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	68	725	218	0	0	9.00
10.00	01000	DIETARY	301	1,208	0	0	0	10.00
11.00	01100	CAFETERIA	68	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	219	967	170	0	0	13.00
15.00	01500	PHARMACY	205	2,417	1,452	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	219	2,900	128	0	0	16.00
17.00	01700	SOCIAL SERVICE	150	1,208	42	0	0	17.00
23.00	02300	ALLIED HEALTH	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	547	5,075	9,914	3,539	3,368	30.00
31.00	03100	INTENSIVE CARE UNIT	410	8,459	3,098	835	795	31.00
41.00	04100	SUBPROVIDER - IRF	273	2,659	1,223	773	736	41.00
43.00	04300	NURSERY	137	242	0	776	739	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	273	15,226	50,170	7,446	7,087	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	410	1,208	5,265	1,355	1,289	52.00
53.00	05300	ANESTHESIOLOGY	287	242	196	1,076	1,024	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	492	4,109	3,198	11,301	10,576	54.00
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	96	967	2,506	854	813	59.00
60.00	06000	LABORATORY	82	7,250	0	7,545	7,181	60.00
65.00	06500	RESPIRATORY THERAPY	205	967	483	1,462	1,391	65.00
66.00	06600	PHYSICAL THERAPY	588	5,800	831	2,826	2,690	66.00
69.00	06900	ELECTROCARDIOLOGY	232	0	1,456	2,282	2,172	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	27	0	15,802	1,455	1,384	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,306	2,195	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,674	1,593	73.00
74.00	07400	RENAL DIALYSIS	0	242	180	16	16	74.00
76.00	03020	PSYCH SERVICES	260	2,900	29	521	496	76.00
76.02	03022	ENDOSCOPY	0	0	5,677	1,211	1,153	76.02
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	14	967	662	786	748	90.00
91.00	09100	EMERGENCY	410	8,459	3,791	4,443	4,228	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	27	242	511	771	734	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	8,258	87,489	110,896	55,253	52,408	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	14	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	41	725	0	0	0	192.00
194.00	07950	FOUNDATION	0	0	0	0	0	194.00
194.01	07951	CLINIC OF HOPE	41	967	51	0	0	194.01
194.04	07952	COMMUNITY RELATIONS	0	0	0	0	0	194.04
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)	8,354	89,181	110,947	55,253	52,408	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150010

Period:
From 07/01/2012
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Cost Center Description		OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.06	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00510						5.01
5.02	00511						5.02
5.03	00512						5.03
5.04	00513						5.04
5.05	00514						5.05
5.06	00560	1,074,778					5.06
7.00	00700		1,272,983				7.00
8.00	00800	5,285	3,031	21,852			8.00
9.00	00900	22,540	11,789	0	87,942		9.00
10.00	01000	10,694	30,453	411	0	178,943	10.00
11.00	01100	16,885	36,919	0	0	0	11.00
13.00	01300	7,181	15,364	0	87	0	13.00
15.00	01500	68,310	18,717	0	0	0	15.00
16.00	01600	23,351	14,317	0	131	0	16.00
17.00	01700	9,460	16,587	0	44	0	17.00
23.00	02300	2,907	5,242	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	103,214	172,271	7,618	27,539	138,512	30.00
31.00	03100	29,975	32,975	991	6,547	5,975	31.00
41.00	04100	27,803	79,384	1,620	6,547	34,456	41.00
43.00	04300	9,391	9,414	0	1,309	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	126,261	196,688	3,949	13,093	0	50.00
51.00	05100	0	0	0	0	0	51.00
52.00	05200	30,802	19,097	2,105	11,129	0	52.00
53.00	05300	1,586	1,621	0	1,309	0	53.00
54.00	05400	87,633	151,074	1,395	2,662	0	54.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	7,040	2,340	125	524	0	59.00
60.00	06000	84,754	46,221	14	2,706	0	60.00
65.00	06500	27,141	7,237	0	131	0	65.00
66.00	06600	53,732	66,412	145	655	0	66.00
69.00	06900	24,556	39,382	209	131	0	69.00
71.00	07100	45,441	25,211	0	2,444	0	71.00
72.00	07200	46,932	0	0	0	0	72.00
73.00	07300	4,203	0	0	1,047	0	73.00
74.00	07400	2,039	0	0	436	0	74.00
76.00	03020	17,219	26,861	0	0	0	76.00
76.02	03022	10,671	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	10,454	17,552	0	1,397	0	90.00
91.00	09100	53,578	113,155	3,085	8,074	0	91.00
92.00	09200						92.00
92.01	09201	0	0	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	16,322	23,216	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		1,049,985	1,182,530	21,667	87,942	178,943	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	327	6,020	0	0	0	190.00
192.00	19200	4,940	84,433	185	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	4,945	0	0	0	0	194.01
194.04	07952	14,581	0	0	0	0	194.04
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		1,074,778	1,272,983	21,852	87,942	178,943	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150010

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

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Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		11.00	13.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00510						5.01
5.02	00511						5.02
5.03	00512						5.03
5.04	00513						5.04
5.05	00514						5.05
5.06	00560						5.06
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	218,594					11.00
13.00	01300	1,930	97,586				13.00
15.00	01500	7,040	0	194,476			15.00
16.00	01600	8,933	0	0	121,247		16.00
17.00	01700	2,992	0	0	0	108,121	17.00
23.00	02300	1,082	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	43,513	21,596	0	7,786	73,074	30.00
31.00	03100	9,241	4,586	0	1,837	9,391	31.00
41.00	04100	10,742	5,332	0	1,702	18,052	41.00
43.00	04300	2,923	1,451	0	1,708	7,604	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	26,799	13,301	0	16,382	0	50.00
51.00	05100	0	0	0	0	0	51.00
52.00	05200	11,061	5,490	0	2,981	0	52.00
53.00	05300	0	0	0	2,366	0	53.00
54.00	05400	22,337	11,087	0	24,551	0	54.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	782	388	0	1,879	0	59.00
60.00	06000	0	0	0	16,600	0	60.00
65.00	06500	9,673	4,801	0	3,216	0	65.00
66.00	06600	16,611	8,245	0	6,218	0	66.00
69.00	06900	8,116	4,028	0	5,020	0	69.00
71.00	07100	3,950	1,960	0	3,200	0	71.00
72.00	07200	0	0	0	5,073	0	72.00
73.00	07300	0	0	194,476	3,683	0	73.00
74.00	07400	0	0	0	36	0	74.00
76.00	03020	4,817	2,391	0	1,146	0	76.00
76.02	03022	2,284	1,134	0	2,664	0	76.02
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	1,573	780	0	1,729	0	90.00
91.00	09100	11,259	5,588	0	9,774	0	91.00
92.00	09200						92.00
92.01	09201	0	0	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	9,133	4,533	0	1,696	0	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		216,791	96,691	194,476	121,247	108,121	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	1,803	895	0	0	0	194.01
194.04	07952	0	0	0	0	0	194.04
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		218,594	97,586	194,476	121,247	108,121	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150010

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From 07/01/2012
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Cost Center Description			ALLIED HEALTH	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			23.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00510	NONPATIENT TELEPHONES					5.01
5.02	00511	DATA PROCESSING					5.02
5.03	00512	PURCHASING, RECEIVING AND STORES					5.03
5.04	00513	ADMITTING					5.04
5.05	00514	CASHIERING/ACCOUNTS RECEIVABLE					5.05
5.06	00560	OTHER ADMINISTRATIVE AND GENERAL					5.06
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
23.00	02300	ALLIED HEALTH	34,012				23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS		1,433,096	0	1,433,096	30.00
31.00	03100	INTENSIVE CARE UNIT		273,793	0	273,793	31.00
41.00	04100	SUBPROVIDER - IRF		556,955	0	556,955	41.00
43.00	04300	NURSERY		81,415	0	81,415	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM		1,385,965	0	1,385,965	50.00
51.00	05100	RECOVERY ROOM		0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		191,468	0	191,468	52.00
53.00	05300	ANESTHESIOLOGY		16,938	0	16,938	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		1,032,507	0	1,032,507	54.00
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		29,899	0	29,899	59.00
60.00	06000	LABORATORY		378,582	0	378,582	60.00
65.00	06500	RESPIRATORY THERAPY		101,545	0	101,545	65.00
66.00	06600	PHYSICAL THERAPY		483,745	0	483,745	66.00
69.00	06900	ELECTROCARDIOLOGY		273,162	0	273,162	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		216,390	0	216,390	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		56,506	0	56,506	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		206,676	0	206,676	73.00
74.00	07400	RENAL DIALYSIS		2,965	0	2,965	74.00
76.00	03020	PSYCH SERVICES		183,322	0	183,322	76.00
76.02	03022	ENDOSCOPY		27,965	0	27,965	76.02
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC		116,454	0	116,454	90.00
91.00	09100	EMERGENCY		746,083	0	746,083	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0		92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)		0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES		168,107	0	168,107	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	7,963,538	0	7,963,538	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN		33,223	0	33,223	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES		467,044	0	467,044	192.00
194.00	07950	FOUNDATION		0	0	0	194.00
194.01	07951	CLINIC OF HOPE		10,768	0	10,768	194.01
194.04	07952	COMMUNITY RELATIONS		14,581	0	14,581	194.04
200.00		Cross Foot Adjustments	34,012	34,012	0	34,012	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	34,012	8,523,166	0	8,523,166	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150010

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

Worksheet B-1
Date/Time Prepared:
11/26/2013 6:05 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (# OF PHONES)	DATA PROCESSING (# OF TERMINALS)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (NO STATISTICAL)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	326,497	0			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		0			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	12,820	0	38,640,858		4.00
5.01 00510	NONPATIENT TELEPHONES	320	0	0	611	5.01
5.02 00511	DATA PROCESSING	3,326	0	224,684	30	738 5.02
5.03 00512	PURCHASING, RECEIVING AND STORES	4,088	0	325,286	15	10 5.03
5.04 00513	ADMINISTRATIVE	1,644	0	1,063,394	12	20 5.04
5.05 00514	CASHIERING/ACCOUNTS RECEIVABLE	1,884	0	258,235	14	6 5.05
5.06 00560	OTHER ADMINISTRATIVE AND GENERAL	38,851	0	5,665,460	81	60 5.06
7.00 00700	OPERATION OF PLANT	45,990	0	931,188	12	12 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	518	0	0	1	0 8.00
9.00 00900	HOUSEKEEPING	2,015	0	97	5	6 9.00
10.00 01000	DIETARY	5,205	0	0	22	10 10.00
11.00 01100	CAFETERIA	6,310	0	0	5	0 11.00
13.00 01300	NURSING ADMINISTRATION	2,626	0	359,832	16	8 13.00
15.00 01500	PHARMACY	3,199	0	1,480,728	15	20 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	2,447	0	853,094	16	24 16.00
17.00 01700	SOCIAL SERVICE	2,835	0	419,195	11	10 17.00
23.00 02300	ALLIED HEALTH	896	0	160,577	0	0 23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	29,444	0	5,414,835	40	42 30.00
31.00 03100	INTENSIVE CARE UNIT	5,636	0	1,333,690	30	70 31.00
41.00 04100	SUBPROVIDER - I/R	13,568	0	1,323,422	20	22 41.00
43.00 04300	NURSERY	1,609	0	429,240	10	2 43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	33,617	0	3,662,595	20	126 50.00
51.00 05100	RECOVERY ROOM	0	0	0	0	0 51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	3,264	0	1,624,500	30	10 52.00
53.00 05300	ANESTHESIOLOGY	277	0	0	21	2 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	25,821	0	3,237,244	36	34 54.00
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	400	0	131,930	7	8 59.00
60.00 06000	LABORATORY	7,900	0	0	6	60 60.00
65.00 06500	RESPIRATORY THERAPY	1,237	0	1,448,537	15	8 65.00
66.00 06600	PHYSICAL THERAPY	11,351	0	2,618,049	43	48 66.00
69.00 06900	ELECTROCARDIOLOGY	6,731	0	1,139,187	17	0 69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,309	0	349,851	2	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	2 74.00
76.00 03020	PSYCH SERVICES	4,591	0	789,012	19	24 76.00
76.02 03022	ENDOSCOPY	0	0	366,118	0	0 76.02
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	3,000	0	170,489	1	8 90.00
91.00 09100	EMERGENCY	19,340	0	1,774,690	30	70 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
92.01 09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0 92.01
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	3,968	0	847,190	2	2 95.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	311,037	0	38,402,349	604	724 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,029	0	0	1	0 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	14,431	0	0	3	6 192.00
194.00 07950	FOUNDATION	0	0	0	0	0 194.00
194.01 07951	CLINIC OF HOPE	0	0	238,509	3	8 194.01
194.04 07952	COMMUNITY RELATIONS	0	0	0	0	0 194.04
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)	8,523,166	0	11,754,781	553,760	4,929,261 202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	26.104883	0.000000	0.304206	906.317512	6,679.215447 203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			334,665	8,354	89,181 204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.008661	13.672668	120.841463 205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150010

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

Worksheet B-1

Date/Time Prepared: 11/26/2013 6:05 pm

Cost Center Description			PURCHASING, RECEIVING AND STORES (COSTED REQUISITION)	ADMITTING (GROSS REVENUE)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS REVENUE)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	
			5.03	5.04	5.05	5A.06	5.06	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00510	NONPATIENT TELEPHONES						5.01
5.02	00511	DATA PROCESSING						5.02
5.03	00512	PURCHASING, RECEIVING AND STORES	5,669,602					5.03
5.04	00513	ADMITTING	27,890	379,798,281				5.04
5.05	00514	CASHIERING/ACCOUNTS RECEIVABLE	3,736	0	379,798,281			5.05
5.06	00560	OTHER ADMINISTRATIVE AND GENERAL	161,311	0	0	-12,831,702	91,266,098	5.06
7.00	00700	OPERATION OF PLANT	6,039	0	0	0	5,318,030	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	448,813	8.00
9.00	00900	HOUSEKEEPING	11,127	0	0	0	1,914,061	9.00
10.00	01000	DIETARY	0	0	0	0	908,112	10.00
11.00	01100	CAFETERIA	0	0	0	0	1,433,846	11.00
13.00	01300	NURSING ADMINISTRATION	8,696	0	0	0	609,777	13.00
15.00	01500	PHARMACY	74,212	0	0	0	5,800,754	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	6,518	0	0	0	1,982,930	16.00
17.00	01700	SOCIAL SERVICE	2,153	0	0	0	803,295	17.00
23.00	02300	ALLIED HEALTH	0	0	0	0	246,844	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	506,601	24,408,625	24,408,625	0	8,764,738	30.00
31.00	03100	INTENSIVE CARE UNIT	158,337	5,758,762	5,758,762	0	2,545,410	31.00
41.00	04100	SUBPROVIDER - IIRF	62,519	5,334,089	5,334,089	0	2,360,973	41.00
43.00	04300	NURSERY	0	5,353,444	5,353,444	0	797,503	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,563,791	51,353,451	51,353,451	0	10,719,693	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	269,065	9,343,581	9,343,581	0	2,615,661	52.00
53.00	05300	ANESTHESIOLOGY	10,017	7,417,719	7,417,719	0	134,640	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	163,402	76,675,677	76,675,677	0	7,441,649	54.00
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	128,078	5,890,906	5,890,906	0	597,812	59.00
60.00	06000	LABORATORY	0	52,037,432	52,037,432	0	7,197,167	60.00
65.00	06500	RESPIRATORY THERAPY	24,668	10,081,775	10,081,775	0	2,304,771	65.00
66.00	06600	PHYSICAL THERAPY	42,467	19,492,139	19,492,139	0	4,562,832	66.00
69.00	06900	ELECTROCARDIOLOGY	74,383	15,736,986	15,736,986	0	2,085,279	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	807,506	10,032,429	10,032,429	0	3,858,796	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	15,902,748	15,902,748	0	3,985,361	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	11,545,579	11,545,579	0	356,921	73.00
74.00	07400	RENAL DIALYSIS	9,198	112,933	112,933	0	173,151	74.00
76.00	03020	PSYCH SERVICES	1,505	3,592,659	3,592,659	0	1,462,233	76.00
76.02	03022	ENDOSCOPY	290,123	8,351,879	8,351,879	0	906,201	76.02
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	33,814	5,420,542	5,420,542	0	887,704	90.00
91.00	09100	EMERGENCY	193,708	30,639,240	30,639,240	0	4,549,723	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	26,130	5,315,686	5,315,686	0	1,386,069	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	5,666,994	379,798,281	379,798,281	-12,831,702	89,160,749	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	27,768	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	419,514	192.00
194.00	07950	FOUNDATION	0	0	0	0	0	194.00
194.01	07951	CLINIC OF HOPE	2,608	0	0	0	419,893	194.01
194.04	07952	COMMUNITY RELATIONS	0	0	0	0	1,238,174	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,492,256	1,712,346	2,228,982		12,831,702	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.263203	0.004509	0.005869		0.140597	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	110,947	55,253	52,408		1,074,778	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.019569	0.000145	0.000138		0.011776	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150010

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

Worksheet B-1

Date/Time Prepared:
11/26/2013 6:05 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MANHOURS)		
		7.00	8.00	9.00	10.00	11.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.01	00510	NONPATIENT TELEPHONES					5.01	
5.02	00511	DATA PROCESSING					5.02	
5.03	00512	PURCHASING, RECEIVING AND STORES					5.03	
5.04	00513	ADMINISTRATIVE					5.04	
5.05	00514	CASHIERING/ACCOUNTS RECEIVABLE					5.05	
5.06	00560	OTHER ADMINISTRATIVE AND GENERAL					5.06	
7.00	00700	OPERATION OF PLANT	217,574				7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	518	725,688			8.00	
9.00	00900	HOUSEKEEPING	2,015	0	2,015		9.00	
10.00	01000	DIETARY	5,205	13,646	0	68,615	10.00	
11.00	01100	CAFETERIA	6,310	0	0	0	11.00	
13.00	01300	NURSING ADMINISTRATION	2,626	0	2	0	13.00	
15.00	01500	PHARMACY	3,199	0	0	0	15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	2,447	0	3	0	16.00	
17.00	01700	SOCIAL SERVICE	2,835	0	1	0	17.00	
23.00	02300	ALLIED HEALTH	896	0	0	0	23.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	29,444	252,985	631	53,112	235,064	30.00
31.00	03100	INTENSIVE CARE UNIT	5,636	32,913	150	2,291	49,919	31.00
41.00	04100	SUBPROVIDER - IIRF	13,568	53,784	150	13,212	58,032	41.00
43.00	04300	NURSERY	1,609	0	30	0	15,788	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	33,617	131,141	300	0	144,770	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,264	69,913	255	0	59,753	52.00
53.00	05300	ANESTHESIOLOGY	277	0	30	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	25,821	46,340	61	0	120,669	54.00
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	400	4,159	12	0	4,227	59.00
60.00	06000	LABORATORY	7,900	467	62	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,237	0	3	0	52,253	65.00
66.00	06600	PHYSICAL THERAPY	11,351	4,816	15	0	89,736	66.00
69.00	06900	ELECTROCARDIOLOGY	6,731	6,933	3	0	43,843	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,309	0	56	0	21,336	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	24	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	10	0	0	74.00
76.00	03020	PSYCH SERVICES	4,591	0	0	0	26,024	76.00
76.02	03022	ENDOSCOPY	0	0	0	0	12,341	76.02
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	3,000	0	32	0	8,495	90.00
91.00	09100	EMERGENCY	19,340	102,461	185	0	60,825	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	3,968	0	0	0	49,335	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	202,114	719,558	2,015	68,615	1,171,130	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,029	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	14,431	6,130	0	0	0	192.00
194.00	07950	FOUNDATION	0	0	0	0	0	194.00
194.01	07951	CLINIC OF HOPE	0	0	0	0	9,742	194.01
194.04	07952	COMMUNITY RELATIONS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	6,065,729	526,356	2,239,348	1,190,798	1,811,356	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	27.878924	0.725320	1,111.338958	17.354777	1.533914	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,272,983	21,852	87,942	178,943	218,594	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	5.850805	0.030112	43.643672	2.607928	0.185112	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150010

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

Worksheet B-1
Date/Time Prepared:
11/26/2013 6:05 pm

Cost Center Description		NURSING ADMINISTRATION (DIRECT NRSNG HRS)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (PATIENT DAYS)	ALLIED HEALTH (ASSIGNED TIME)	
		13.00	15.00	16.00	17.00	23.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00510						5.01
5.02	00511						5.02
5.03	00512						5.03
5.04	00513						5.04
5.05	00514						5.05
5.06	00560						5.06
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300	1,062,152					13.00
15.00	01500	0	1,000				15.00
16.00	01600	0	0	379,798,281			16.00
17.00	01700	0	0	0	26,377		17.00
23.00	02300	0	0	0	0	100	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	235,064	0	24,408,625	17,827	0	30.00
31.00	03100	49,919	0	5,758,762	2,291	0	31.00
41.00	04100	58,032	0	5,334,089	4,404	0	41.00
43.00	04300	15,788	0	5,353,444	1,855	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	144,770	0	51,353,451	0	0	50.00
51.00	05100	0	0	0	0	0	51.00
52.00	05200	59,753	0	9,343,581	0	0	52.00
53.00	05300	0	0	7,417,719	0	0	53.00
54.00	05400	120,669	0	76,675,677	0	100	54.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	4,227	0	5,890,906	0	0	59.00
60.00	06000	0	0	52,037,432	0	0	60.00
65.00	06500	52,253	0	10,081,775	0	0	65.00
66.00	06600	89,736	0	19,492,139	0	0	66.00
69.00	06900	43,843	0	15,736,986	0	0	69.00
71.00	07100	21,336	0	10,032,429	0	0	71.00
72.00	07200	0	0	15,902,748	0	0	72.00
73.00	07300	0	1,000	11,545,579	0	0	73.00
74.00	07400	0	0	112,933	0	0	74.00
76.00	03020	26,024	0	3,592,659	0	0	76.00
76.02	03022	12,341	0	8,351,879	0	0	76.02
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	8,495	0	5,420,542	0	0	90.00
91.00	09100	60,825	0	30,639,240	0	0	91.00
92.00	09200						92.00
92.01	09201	0	0	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	49,335	0	5,315,686	0	0	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		1,052,410	1,000	379,798,281	26,377	100	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	9,742	0	0	0	0	194.01
194.04	07952	0	0	0	0	0	194.04
200.00							200.00
201.00							201.00
202.00		786,934	6,763,843	2,407,297	1,021,180	315,496	202.00
203.00		0.740886	6,763.843000	0.006338	38.714789	3,154.960000	203.00
204.00		97,586	194,476	121,247	108,121	34,012	204.00
205.00		0.091876	194.476000	0.000319	4.099064	340.120000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150010	Period: From 07/01/2012 To 06/30/2013	Worksheet C Part I Date/Time Prepared: 11/26/2013 6:05 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	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS		14,003,990	0	14,003,990	30.00
31.00	03100 INTENSIVE CARE UNIT		3,529,496	0	3,529,496	31.00
41.00	04100 SUBPROVIDER - I RF		3,842,501	0	3,842,501	41.00
43.00	04300 NURSERY		1,129,487	0	1,129,487	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM		14,247,336	0	14,247,336	50.00
51.00	05100 RECOVERY ROOM		0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		3,603,658	0	3,603,658	52.00
53.00	05300 ANESTHESIOLOGY		241,646	0	241,646	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		10,385,287	0	10,385,287	54.00
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		756,321	0	756,321	59.00
60.00	06000 LABORATORY		8,828,365	0	8,828,365	60.00
65.00	06500 RESPIRATORY THERAPY	0	2,849,399	0	2,849,399	65.00
66.00	06600 PHYSICAL THERAPY	0	5,868,641	0	5,868,641	66.00
69.00	06900 ELECTROCARDIOLOGY		2,773,954	0	2,773,954	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		4,695,818	0	4,695,818	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		4,646,483	0	4,646,483	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		7,270,794	0	7,270,794	73.00
74.00	07400 RENAL DIALYSIS		209,325	0	209,325	74.00
76.00	03020 PSYCH SERVICES		1,877,781	0	1,877,781	76.00
76.02	03022 ENDOSCOPY		1,114,617	0	1,114,617	76.02
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC		1,185,393	0	1,185,393	90.00
91.00	09100 EMERGENCY		6,341,049	0	6,341,049	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		883,212	0	883,212	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)		0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES		1,837,489	0	1,837,489	95.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)		102,122,042	0	102,122,042	200.00
201.00	Less Observation Beds		883,212	0	883,212	201.00
202.00	Total (see instructions)		101,238,830	0	101,238,830	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150010	Period: From 07/01/2012 To 06/30/2013	Worksheet C Part I Date/Time Prepared: 11/26/2013 6:05 pm
		Title XVII I	Hospital	PPS

Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				
	9.00	10.00					
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	23,982,258		23,982,258		30.00
31.00	03100	INTENSIVE CARE UNIT	5,758,762		5,758,762		31.00
41.00	04100	SUBPROVIDER - IRF	5,334,089		5,334,089		41.00
43.00	04300	NURSERY	5,353,444		5,353,444		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	17,835,790	33,517,661	51,353,451	0.277437	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,381,951	961,630	9,343,581	0.385683	52.00
53.00	05300	ANESTHESIOLOGY	2,880,763	4,536,956	7,417,719	0.032577	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,247,715	63,427,962	76,675,677	0.135444	54.00
57.00	05700	CT SCAN	0	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,061,797	4,829,109	5,890,906	0.128388	59.00
60.00	06000	LABORATORY	20,629,342	31,408,090	52,037,432	0.169654	60.00
65.00	06500	RESPIRATORY THERAPY	8,707,115	1,374,660	10,081,775	0.282629	65.00
66.00	06600	PHYSICAL THERAPY	9,296,089	10,196,050	19,492,139	0.301077	66.00
69.00	06900	ELECTROCARDIOLOGY	3,933,637	11,803,349	15,736,986	0.176270	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,014,702	2,017,727	10,032,429	0.468064	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,561,059	4,341,689	15,902,748	0.292181	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,677,130	3,868,449	11,545,579	0.629747	73.00
74.00	07400	RENAL DIALYSIS	112,933	0	112,933	1.853533	74.00
76.00	03020	PSYCH SERVICES	491,504	3,101,155	3,592,659	0.522672	76.00
76.02	03022	ENDOSCOPY	0	8,351,879	8,351,879	0.133457	76.02
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	5,420,542	5,420,542	0.218685	90.00
91.00	09100	EMERGENCY	6,515,859	24,123,381	30,639,240	0.206958	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	426,367	426,367	2.071483	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0.000000	92.01
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	63,011	5,252,675	5,315,686	0.345673	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	160,838,950	218,959,331	379,798,281		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	160,838,950	218,959,331	379,798,281		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150010	Period: From 07/01/2012 To 06/30/2013	Worksheet C Part I Date/Time Prepared: 11/26/2013 6:05 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
31.00	03100 INTENSIVE CARE UNIT			31.00
41.00	04100 SUBPROVIDER - IRF			41.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.277437		50.00
51.00	05100 RECOVERY ROOM	0.000000		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.385683		52.00
53.00	05300 ANESTHESIOLOGY	0.032577		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.135444		54.00
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	0.128388		59.00
60.00	06000 LABORATORY	0.169654		60.00
65.00	06500 RESPIRATORY THERAPY	0.282629		65.00
66.00	06600 PHYSICAL THERAPY	0.301077		66.00
69.00	06900 ELECTROCARDIOLOGY	0.176270		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.468064		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.292181		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.629747		73.00
74.00	07400 RENAL DIALYSIS	1.853533		74.00
76.00	03020 PSYCH SERVICES	0.522672		76.00
76.02	03022 ENDOSCOPY	0.133457		76.02
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.218685		90.00
91.00	09100 EMERGENCY	0.206958		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2.071483		92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0.000000		92.01
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0.345673		95.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE			113.00
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: 150010

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

Worksheet C
Part I
Date/Time Prepared:
11/26/2013 6:05 pm

		Title XIX		Hospital		Cost
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	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	14,003,990	14,003,990	0	0	30.00
31.00	03100 INTENSIVE CARE UNIT	3,529,496	3,529,496	0	0	31.00
41.00	04100 SUBPROVIDER - I RF	3,842,501	3,842,501	0	0	41.00
43.00	04300 NURSERY	1,129,487	1,129,487	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	14,247,336	14,247,336	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	3,603,658	3,603,658	0	0	52.00
53.00	05300 ANESTHESIOLOGY	241,646	241,646	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	10,385,287	10,385,287	0	0	54.00
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	756,321	756,321	0	0	59.00
60.00	06000 LABORATORY	8,828,365	8,828,365	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	2,849,399	2,849,399	0	0	65.00
66.00	06600 PHYSICAL THERAPY	5,868,641	5,868,641	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	2,773,954	2,773,954	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4,695,818	4,695,818	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	4,646,483	4,646,483	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	7,270,794	7,270,794	0	0	73.00
74.00	07400 RENAL DIALYSIS	209,325	209,325	0	0	74.00
76.00	03020 PSYCH SERVICES	1,877,781	1,877,781	0	0	76.00
76.02	03022 ENDOSCOPY	1,114,617	1,114,617	0	0	76.02
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	1,185,393	1,185,393	0	0	90.00
91.00	09100 EMERGENCY	6,341,049	6,341,049	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	883,212	883,212	0	0	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	1,837,489	1,837,489	0	0	95.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)	102,122,042	102,122,042	0	0	200.00
201.00	Less Observation Beds	883,212	883,212	0	0	201.00
202.00	Total (see instructions)	101,238,830	101,238,830	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150010

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

Worksheet C
Part I
Date/Time Prepared:
11/26/2013 6:05 pm

		Title XIX			Hospital	Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	23,982,258		23,982,258		30.00
31.00	03100	INTENSIVE CARE UNIT	5,758,762		5,758,762		31.00
41.00	04100	SUBPROVIDER - IRF	5,334,089		5,334,089		41.00
43.00	04300	NURSERY	5,353,444		5,353,444		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	17,835,790	33,517,661	51,353,451	0.277437	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,381,951	961,630	9,343,581	0.385683	52.00
53.00	05300	ANESTHESIOLOGY	2,880,763	4,536,956	7,417,719	0.032577	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,247,715	63,427,962	76,675,677	0.135444	54.00
57.00	05700	CT SCAN	0	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,061,797	4,829,109	5,890,906	0.128388	59.00
60.00	06000	LABORATORY	20,629,342	31,408,090	52,037,432	0.169654	60.00
65.00	06500	RESPIRATORY THERAPY	8,707,115	1,374,660	10,081,775	0.282629	65.00
66.00	06600	PHYSICAL THERAPY	9,296,089	10,196,050	19,492,139	0.301077	66.00
69.00	06900	ELECTROCARDIOLOGY	3,933,637	11,803,349	15,736,986	0.176270	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,014,702	2,017,727	10,032,429	0.468064	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,561,059	4,341,689	15,902,748	0.292181	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,677,130	3,868,449	11,545,579	0.629747	73.00
74.00	07400	RENAL DIALYSIS	112,933	0	112,933	1.853533	74.00
76.00	03020	PSYCH SERVICES	491,504	3,101,155	3,592,659	0.522672	76.00
76.02	03022	ENDOSCOPY	0	8,351,879	8,351,879	0.133457	76.02
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	5,420,542	5,420,542	0.218685	90.00
91.00	09100	EMERGENCY	6,515,859	24,123,381	30,639,240	0.206958	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	426,367	426,367	2.071483	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0.000000	92.01
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	63,011	5,252,675	5,315,686	0.345673	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	160,838,950	218,959,331	379,798,281		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	160,838,950	218,959,331	379,798,281		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150010	Period: From 07/01/2012 To 06/30/2013	Worksheet C Part I Date/Time Prepared: 11/26/2013 6:05 pm
Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital Cost
	INPATIENT ROUTINE SERVICE COST CENTERS	11.00		
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
41.00	04100 SUBPROVIDER - IRF			41.00
43.00	04300 NURSERY			43.00
	ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0.000000		50.00
51.00	05100 RECOVERY ROOM	0.000000		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
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
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
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
76.00	03020 PSYCH SERVICES	0.000000		76.00
76.02	03022 ENDOSCOPY	0.000000		76.02
	OUTPATIENT SERVICE COST CENTERS			
90.00	09000 CLINIC	0.000000		90.00
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0.000000		92.01
	OTHER REIMBURSABLE COST CENTERS			
95.00	09500 AMBULANCE SERVICES	0.000000		95.00
	SPECIAL PURPOSE COST CENTERS			
113.00	11300 INTEREST EXPENSE			113.00
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: 150010		Period: From 07/01/2012 To 06/30/2013		Worksheet D Part I Date/Time Prepared: 11/26/2013 6:05 pm		
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)		
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	1,433,096	0	1,433,096	19,027	75.32	30.00	
31.00	INTENSIVE CARE UNIT	273,793	0	273,793	2,291	119.51	31.00	
41.00	SUBPROVIDER - IRF	556,955	0	556,955	4,404	126.47	41.00	
43.00	NURSERY	81,415		81,415	1,855	43.89	43.00	
200.00	Total (lines 30-199)	2,345,259		2,345,259	27,577		200.00	
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)					
		6.00	7.00					
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	8,171	615,440					30.00
31.00	INTENSIVE CARE UNIT	1,496	178,787					31.00
41.00	SUBPROVIDER - IRF	3,272	413,810					41.00
43.00	NURSERY	0	0					43.00
200.00	Total (lines 30-199)	12,939	1,208,037					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 150010

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

Worksheet D
Part II
Date/Time Prepared:
11/26/2013 6:05 pm

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	1,385,965	51,353,451	0.026989	10,207,319	275,485	50.00
51.00	05100 RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	191,468	9,343,581	0.020492	29,960	614	52.00
53.00	05300 ANESTHESIOLOGY	16,938	7,417,719	0.002283	1,450,744	3,312	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,032,507	76,675,677	0.013466	7,617,815	102,581	54.00
57.00	05700 CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	29,899	5,890,906	0.005075	284,028	1,441	59.00
60.00	06000 LABORATORY	378,582	52,037,432	0.007275	11,286,148	82,107	60.00
65.00	06500 RESPIRATORY THERAPY	101,545	10,081,775	0.010072	4,772,604	48,070	65.00
66.00	06600 PHYSICAL THERAPY	483,745	19,492,139	0.024817	2,969,509	73,694	66.00
69.00	06900 ELECTROCARDIOLOGY	273,162	15,736,986	0.017358	3,456,024	59,990	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	216,390	10,032,429	0.021569	4,366,430	94,180	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	56,506	15,902,748	0.003553	6,233,355	22,147	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	206,676	11,545,579	0.017901	4,459,477	79,829	73.00
74.00	07400 RENAL DIALYSIS	2,965	112,933	0.026255	62,201	1,633	74.00
76.00	03020 PSYCH SERVICES	183,322	3,592,659	0.051027	0	0	76.00
76.02	03022 ENDOSCOPY	27,965	8,351,879	0.003348	0	0	76.02
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	116,454	5,420,542	0.021484	0	0	90.00
91.00	09100 EMERGENCY	746,083	30,639,240	0.024351	3,714,336	90,448	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	90,384	426,367	0.211986	0	0	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0.000000	0	0	92.01
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	5,540,556	334,054,042		60,909,950	935,531	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 150010		Period: From 07/01/2012 To 06/30/2013		Worksheet D Part III Date/Time Prepared: 11/26/2013 6:05 pm	
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	19,027	0.00	8,171	0		30.00
31.00	03100	INTENSIVE CARE UNIT	2,291	0.00	1,496	0		31.00
41.00	04100	SUBPROVIDER - IRF	4,404	0.00	3,272	0		41.00
43.00	04300	NURSERY	1,855	0.00	0	0		43.00
200.00		Total (lines 30-199)	27,577		12,939	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150010

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

Worksheet D
Part IV
Date/Time Prepared:
11/26/2013 6:05 pm

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		
ANCILLARY SERVICE COST CENTERS								
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00	
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00	
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	315,496	0	315,496	54.00	
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	
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00	
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00	
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00	
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	
76.00	03020 PSYCH SERVICES	0	0	0	0	0	76.00	
76.02	03022 ENDOSCOPY	0	0	0	0	0	76.02	
OUTPATIENT SERVICE COST CENTERS								
90.00	09000 CLINIC	0	0	0	0	0	90.00	
91.00	09100 EMERGENCY	0	0	0	0	0	91.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00	
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01	
OTHER REIMBURSABLE COST CENTERS								
95.00	09500 AMBULANCE SERVICES						95.00	
200.00	Total (lines 50-199)	0	0	315,496	0	315,496	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150010	Period: From 07/01/2012 To 06/30/2013	Worksheet D Part IV Date/Time Prepared: 11/26/2013 6:05 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	51,353,451	0.000000	0.000000	10,207,319	50.00
51.00	05100 RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	9,343,581	0.000000	0.000000	29,960	52.00
53.00	05300 ANESTHESIOLOGY	0	7,417,719	0.000000	0.000000	1,450,744	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	315,496	76,675,677	0.004115	0.004115	7,617,815	54.00
57.00	05700 CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	5,890,906	0.000000	0.000000	284,028	59.00
60.00	06000 LABORATORY	0	52,037,432	0.000000	0.000000	11,286,148	60.00
65.00	06500 RESPIRATORY THERAPY	0	10,081,775	0.000000	0.000000	4,772,604	65.00
66.00	06600 PHYSICAL THERAPY	0	19,492,139	0.000000	0.000000	2,969,509	66.00
69.00	06900 ELECTROCARDIOLOGY	0	15,736,986	0.000000	0.000000	3,456,024	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	10,032,429	0.000000	0.000000	4,366,430	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	15,902,748	0.000000	0.000000	6,233,355	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	11,545,579	0.000000	0.000000	4,459,477	73.00
74.00	07400 RENAL DIALYSIS	0	112,933	0.000000	0.000000	62,201	74.00
76.00	03020 PSYCH SERVICES	0	3,592,659	0.000000	0.000000	0	76.00
76.02	03022 ENDOSCOPY	0	8,351,879	0.000000	0.000000	0	76.02
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	5,420,542	0.000000	0.000000	0	90.00
91.00	09100 EMERGENCY	0	30,639,240	0.000000	0.000000	3,714,336	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	426,367	0.000000	0.000000	0	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0.000000	0.000000	0	92.01
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	315,496	334,054,042			60,909,950	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150010

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

Worksheet D
Part IV
Date/Time Prepared:
11/26/2013 6:05 pm

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		
Title XVIII Hospital PPS						
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	13,208,087	0		50.00
51.00	05100 RECOVERY ROOM	0	0	0		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	4,857	0		52.00
53.00	05300 ANESTHESIOLOGY	0	1,363,544	0		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	31,347	22,479,526	92,503		54.00
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	548,031	0		59.00
60.00	06000 LABORATORY	0	1,240,317	0		60.00
65.00	06500 RESPIRATORY THERAPY	0	498,511	0		65.00
66.00	06600 PHYSICAL THERAPY	0	27,953	0		66.00
69.00	06900 ELECTROCARDIOLOGY	0	10,021,499	0		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,016,960	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	1,075,543	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	3,151,293	0		73.00
74.00	07400 RENAL DIALYSIS	0	0	0		74.00
76.00	03020 PSYCH SERVICES	0	47,202	0		76.00
76.02	03022 ENDOSCOPY	0	0	0		76.02
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	224	0		90.00
91.00	09100 EMERGENCY	0	7,516,482	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	280,886	0		92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0		92.01
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES					95.00
200.00	Total (lines 50-199)	31,347	63,480,915	92,503		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 150010	Period: From 07/01/2012 To 06/30/2013	Worksheet D Part V Date/Time Prepared: 11/26/2013 6:05 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	0.277437	13,208,087	0	0	3,664,412	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.385683	4,857	0	0	1,873	52.00
53.00	05300	ANESTHESIOLOGY	0.032577	1,363,544	0	0	44,420	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.135444	22,479,526	0	0	3,044,717	54.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.128388	548,031	0	0	70,361	59.00
60.00	06000	LABORATORY	0.169654	1,240,317	5,599	0	210,425	60.00
65.00	06500	RESPIRATORY THERAPY	0.282629	498,511	0	0	140,894	65.00
66.00	06600	PHYSICAL THERAPY	0.301077	27,953	0	0	8,416	66.00
69.00	06900	ELECTROCARDIOLOGY	0.176270	10,021,499	0	0	1,766,490	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.468064	2,016,960	767	0	944,066	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.292181	1,075,543	0	0	314,253	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.629747	3,151,293	0	9,942	1,984,517	73.00
74.00	07400	RENAL DIALYSIS	1.853533	0	0	0	0	74.00
76.00	03020	PSYCH SERVICES	0.522672	47,202	0	0	24,671	76.00
76.02	03022	ENDOSCOPY	0.133457	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.218685	224	0	0	49	90.00
91.00	09100	EMERGENCY	0.206958	7,516,482	0	0	1,555,596	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.071483	280,886	0	0	581,851	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	0	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0.345673	0	0	0	0	95.00
200.00		Subtotal (see instructions)		63,480,915	6,366	9,942	14,357,011	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		63,480,915	6,366	9,942	14,357,011	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 150010	Period: From 07/01/2012 To 06/30/2013	Worksheet D Part V Date/Time Prepared: 11/26/2013 6:05 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
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	950	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	359	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	6,261	73.00
74.00	07400 RENAL DIALYSIS	0	0	74.00
76.00	03020 PSYCH SERVICES	0	0	76.00
76.02	03022 ENDOSCOPY	0	0	76.02
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0	0	90.00
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0	92.01
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0	0	95.00
200.00	Subtotal (see instructions)	1,309	6,261	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0	0	201.00
202.00	Net Charges (line 200 +/- line 201)	1,309	6,261	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 150010 Component CCN: 15T010		Period: From 07/01/2012 To 06/30/2013		Worksheet D Part II Date/Time Prepared: 11/26/2013 6:05 pm		
		Title XVIIII		Subprovider - IRF		PPS		
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,385,965	51,353,451	0.026989	41,823	1,129	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	191,468	9,343,581	0.020492	0	0	52.00
53.00	05300	ANESTHESIOLOGY	16,938	7,417,719	0.002283	3,823	9	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,032,507	76,675,677	0.013466	324,705	4,372	54.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	29,899	5,890,906	0.005075	0	0	59.00
60.00	06000	LABORATORY	378,582	52,037,432	0.007275	1,028,016	7,479	60.00
65.00	06500	RESPIRATORY THERAPY	101,545	10,081,775	0.010072	360,734	3,633	65.00
66.00	06600	PHYSICAL THERAPY	483,745	19,492,139	0.024817	3,848,188	95,500	66.00
69.00	06900	ELECTROCARDIOLOGY	273,162	15,736,986	0.017358	275,909	4,789	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	216,390	10,032,429	0.021569	272,843	5,885	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	56,506	15,902,748	0.003553	11,076	39	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	206,676	11,545,579	0.017901	460,169	8,237	73.00
74.00	07400	RENAL DIALYSIS	2,965	112,933	0.026255	7,329	192	74.00
76.00	03020	PSYCH SERVICES	183,322	3,592,659	0.051027	0	0	76.00
76.02	03022	ENDOSCOPY	27,965	8,351,879	0.003348	0	0	76.02
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	116,454	5,420,542	0.021484	0	0	90.00
91.00	09100	EMERGENCY	746,083	30,639,240	0.024351	2,024	49	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	426,367	0.000000	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0.000000	0	0	92.01
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	5,450,172	334,054,042		6,636,639	131,313	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150010
Component CCN: 15T010

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

Worksheet D
Part IV
Date/Time Prepared:
11/26/2013 6:05 pm
PPS

Title XVIII

Subprovider -
IRF

Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	315,496	315,496	54.00
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
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
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
76.00	03020	PSYCH SERVICES	0	0	0	0	76.00
76.02	03022	ENDOSCOPY	0	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
200.00		Total (lines 50-199)	0	0	315,496	315,496	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150010 Component CCN: 15T010	Period: From 07/01/2012 To 06/30/2013	Worksheet D Part IV Date/Time Prepared: 11/26/2013 6:05 pm
		Title XVIII	Subprovider - IRF

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	51,353,451	0.000000	0.000000	41,823	50.00
51.00	05100 RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	9,343,581	0.000000	0.000000	0	52.00
53.00	05300 ANESTHESIOLOGY	0	7,417,719	0.000000	0.000000	3,823	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	315,496	76,675,677	0.004115	0.004115	324,705	54.00
57.00	05700 CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	5,890,906	0.000000	0.000000	0	59.00
60.00	06000 LABORATORY	0	52,037,432	0.000000	0.000000	1,028,016	60.00
65.00	06500 RESPIRATORY THERAPY	0	10,081,775	0.000000	0.000000	360,734	65.00
66.00	06600 PHYSICAL THERAPY	0	19,492,139	0.000000	0.000000	3,848,188	66.00
69.00	06900 ELECTROCARDIOLOGY	0	15,736,986	0.000000	0.000000	275,909	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	10,032,429	0.000000	0.000000	272,843	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	15,902,748	0.000000	0.000000	11,076	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	11,545,579	0.000000	0.000000	460,169	73.00
74.00	07400 RENAL DIALYSIS	0	112,933	0.000000	0.000000	7,329	74.00
76.00	03020 PSYCH SERVICES	0	3,592,659	0.000000	0.000000	0	76.00
76.02	03022 ENDOSCOPY	0	8,351,879	0.000000	0.000000	0	76.02
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	5,420,542	0.000000	0.000000	0	90.00
91.00	09100 EMERGENCY	0	30,639,240	0.000000	0.000000	2,024	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	426,367	0.000000	0.000000	0	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0.000000	0.000000	0	92.01
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	315,496	334,054,042			6,636,639	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150010	Period: From 07/01/2012	Worksheet D Part IV Date/Time Prepared: 11/26/2013 6:05 pm
	Component CCN: 15T010	To 06/30/2013	
Title XVIII		Subprovider - IRF	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	1,336	0	0	54.00
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
65.00	06500 RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	69.00
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
76.00	03020 PSYCH SERVICES	0	0	0	76.00
76.02	03022 ENDOSCOPY	0	0	0	76.02
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0	0	0	90.00
91.00	09100 EMERGENCY	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (lines 50-199)	1,336	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150010	Period: From 07/01/2012 To 06/30/2013	Worksheet D-1 Date/Time Prepared: 11/26/2013 6:05 pm
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		19,027	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		19,027	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.		11,745	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		6,082	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)		8,171	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)		1,680	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		14,003,990	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)		14,003,990	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		23,982,258	28.00
29.00	Private room charges (excluding swing-bed charges)		17,849,641	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		6,132,617	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.583931	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		1,519.77	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		1,008.32	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		511.45	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		298.65	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		3,507,644	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		10,496,346	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		736.01	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		6,013,938	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)		6,013,938	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150010		Period: From 07/01/2012 To 06/30/2013		Worksheet D-1 Date/Time Prepared: 11/26/2013 6:05 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 XVIII		1.00	2.00	3.00	4.00	5.00	
Hospital							
PPS							
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	3,529,496	2,291	1,540.59	1,496	2,304,723	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)					16,283,200	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					24,601,861	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)					794,227	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					966,878	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					1,761,105	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					22,840,756	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					1,200	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					736.01	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					883,212	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150010		Period: From 07/01/2012 To 06/30/2013		Worksheet D-1 Date/Time Prepared: 11/26/2013 6:05 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	1,433,096	14,003,990	0.102335	883,212	90,384	90.00
91.00	Nursing School cost	0	14,003,990	0.000000	883,212	0	91.00
92.00	Allied health cost	0	14,003,990	0.000000	883,212	0	92.00
93.00	All other Medical Education	0	14,003,990	0.000000	883,212	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150010	Period: From 07/01/2012 To 06/30/2013	Worksheet D-1
		Component CCN: 15T010		Date/Time Prepared: 11/26/2013 6:05 pm
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		4,404	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		4,404	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.		1,676	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		2,728	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)		3,272	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)		1,139	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,842,501	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)		3,842,501	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		5,334,089	28.00
29.00	Private room charges (excluding swing-bed charges)		2,034,664	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		3,299,425	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.720367	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		1,214.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		1,209.47	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		4.53	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		3.26	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		5,464	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		3,837,037	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		872.50	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,854,820	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)		2,854,820	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150010		Period: From 07/01/2012 To 06/30/2013		Worksheet D-1	
		Component CCN: 15T010				Date/Time Prepared: 11/26/2013 6:05 pm	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	0	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)					1,974,041		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					4,828,861		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)					413,810		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					132,649		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					546,459		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					4,282,402		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: 150010 Component CCN: 15T010		Period: From 07/01/2012 To 06/30/2013		Worksheet D-1 Date/Time Prepared: 11/26/2013 6:05 pm	
		Title XVIII		Subprovider - IRF		PPS	
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	556,955	3,842,501	0.144946	0	0	90.00
91.00	Nursing School cost	0	3,842,501	0.000000	0	0	91.00
92.00	Allied health cost	0	3,842,501	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,842,501	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150010	Period: From 07/01/2012 To 06/30/2013	Worksheet D-1 Date/Time Prepared: 11/26/2013 6:05 pm
Cost Center Description		Title XIX	Hospital	Cost
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		19,027	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		19,027	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.		11,745	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		6,082	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)		988	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)		1,855	15.00
16.00	Nursery days (title V or XIX only)		1,581	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		14,003,990	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)		14,003,990	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		23,982,258	28.00
29.00	Private room charges (excluding swing-bed charges)		17,849,641	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		6,132,617	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.583931	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		1,519.77	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		1,008.32	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		511.45	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		298.65	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		3,507,644	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		10,496,346	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		551.66	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		545,040	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)		545,040	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150010		Period: From 07/01/2012 To 06/30/2013		Worksheet D-1	
Date/Time Prepared: 11/26/2013 6:05 pm		Title XIX		Hospital		Cost	
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)		
42.00 NURSERY (title V & XIX only)	1,129,487	1,855	608.89	1,581	962,655		42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	3,529,496	2,291	1,540.59	0	0		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)					1,296,413		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,804,108		49.00
PASS THROUGH COST ADJUSTMENTS							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						0	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						0	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)						0	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges						0	54.00
55.00 Target amount per discharge						0.00	55.00
56.00 Target amount (line 54 x line 55)						0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0	57.00
58.00 Bonus payment (see instructions)						0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						0	61.00
62.00 Relief payment (see instructions)						0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)						0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)						1,200	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						736.01	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)						883,212	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 150010

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

Worksheet D-1
Date/Time Prepared:
11/26/2013 6:05 pm

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150010	Period: From 07/01/2012 To 06/30/2013	Worksheet D-3 Date/Time Prepared: 11/26/2013 6:05 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		9,918,190		30.00
31.00	03100 INTENSIVE CARE UNIT		4,059,403		31.00
41.00	04100 SUBPROVIDER - IRF		0		41.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.277437	10,207,319	2,831,888	50.00
51.00	05100 RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.385683	29,960	11,555	52.00
53.00	05300 ANESTHESIOLOGY	0.032577	1,450,744	47,261	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.135444	7,617,815	1,031,787	54.00
57.00	05700 CT SCAN	0.000000	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.128388	284,028	36,466	59.00
60.00	06000 LABORATORY	0.169654	11,286,148	1,914,740	60.00
65.00	06500 RESPIRATORY THERAPY	0.282629	4,772,604	1,348,876	65.00
66.00	06600 PHYSICAL THERAPY	0.301077	2,969,509	894,051	66.00
69.00	06900 ELECTROCARDIOLOGY	0.176270	3,456,024	609,193	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.468064	4,366,430	2,043,769	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.292181	6,233,355	1,821,268	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.629747	4,459,477	2,808,342	73.00
74.00	07400 RENAL DIALYSIS	1.853533	62,201	115,292	74.00
76.00	03020 PSYCH SERVICES	0.522672	0	0	76.00
76.02	03022 ENDOSCOPY	0.133457	0	0	76.02
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.218685	0	0	90.00
91.00	09100 EMERGENCY	0.206958	3,714,336	768,712	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2.071483	0	0	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0.000000	0	0	92.01
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50-94 and 96-98)		60,909,950	16,283,200	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)		60,909,950		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150010 Component CCN: 15T010	Period: From 07/01/2012 To 06/30/2013	Worksheet D-3 Date/Time Prepared: 11/26/2013 6:05 pm	
		Title XVIII	Subprovider - IRF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
41.00	04100	SUBPROVIDER - IRF		3,971,467	41.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.277437	41,823	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.385683	0	52.00
53.00	05300	ANESTHESIOLOGY	0.032577	3,823	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.135444	324,705	54.00
57.00	05700	CT SCAN	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.128388	0	59.00
60.00	06000	LABORATORY	0.169654	1,028,016	60.00
65.00	06500	RESPIRATORY THERAPY	0.282629	360,734	65.00
66.00	06600	PHYSICAL THERAPY	0.301077	3,848,188	66.00
69.00	06900	ELECTROCARDIOLOGY	0.176270	275,909	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.468064	272,843	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.292181	11,076	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.629747	460,169	73.00
74.00	07400	RENAL DIALYSIS	1.853533	7,329	74.00
76.00	03020	PSYCH SERVICES	0.522672	0	76.00
76.02	03022	ENDOSCOPY	0.133457	0	76.02
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.218685	0	90.00
91.00	09100	EMERGENCY	0.206958	2,024	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.071483	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	0	92.01
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50-94 and 96-98)		6,636,639	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net Charges (line 200 minus line 201)		6,636,639	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150010	Period: From 07/01/2012 To 06/30/2013	Worksheet D-3 Date/Time Prepared: 11/26/2013 6:05 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		1,178,827		30.00
31.00	03100 INTENSIVE CARE UNIT		834,980		31.00
41.00	04100 SUBPROVIDER - IRF		0		41.00
43.00	04300 NURSERY		0		43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.277437	590,823	163,916	50.00
51.00	05100 RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.385683	299,705	115,591	52.00
53.00	05300 ANESTHESIOLOGY	0.032577	117,374	3,824	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.135444	521,520	70,637	54.00
57.00	05700 CT SCAN	0.000000	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.128388	23,710	3,044	59.00
60.00	06000 LABORATORY	0.169654	955,000	162,020	60.00
65.00	06500 RESPIRATORY THERAPY	0.282629	446,611	126,225	65.00
66.00	06600 PHYSICAL THERAPY	0.301077	325,495	97,999	66.00
69.00	06900 ELECTROCARDIOLOGY	0.176270	201,704	35,554	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.468064	274,999	128,717	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.292181	86,788	25,358	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.629747	520,496	327,781	73.00
74.00	07400 RENAL DIALYSIS	1.853533	7,564	14,020	74.00
76.00	03020 PSYCH SERVICES	0.522672	0	0	76.00
76.02	03022 ENDOSCOPY	0.133457	0	0	76.02
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.218685	0	0	90.00
91.00	09100 EMERGENCY	0.206958	104,983	21,727	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2.071483	0	0	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0.000000	0	0	92.01
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50-94 and 96-98)		4,476,772	1,296,413	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)		4,476,772		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150010	Period: From 07/01/2012 To 06/30/2013	Worksheet D-3	
		Component CCN: 15T010		Date/Time Prepared: 11/26/2013 6:05 pm	
		Title XIX	Subprovider - IRF	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
41.00	04100	SUBPROVIDER - IRF		49,752	41.00
43.00	04300	NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.277437	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.385683	0	52.00
53.00	05300	ANESTHESIOLOGY	0.032577	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.135444	0	54.00
57.00	05700	CT SCAN	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.128388	0	59.00
60.00	06000	LABORATORY	0.169654	3,392	60.00
65.00	06500	RESPIRATORY THERAPY	0.282629	0	65.00
66.00	06600	PHYSICAL THERAPY	0.301077	38,049	66.00
69.00	06900	ELECTROCARDIOLOGY	0.176270	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.468064	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.292181	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.629747	9,173	73.00
74.00	07400	RENAL DIALYSIS	1.853533	0	74.00
76.00	03020	PSYCH SERVICES	0.522672	0	76.00
76.02	03022	ENDOSCOPY	0.133457	0	76.02
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.218685	0	90.00
91.00	09100	EMERGENCY	0.206958	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.071483	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	0	92.01
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50-94 and 96-98)		50,614	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net Charges (line 200 minus line 201)		50,614	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150010	Period: From 07/01/2012 To 06/30/2013	Worksheet E Part A Date/Time Prepared: 11/26/2013 6:05 pm	
		Title XVIII	Hospital	PPS	
		0	before 1/1	on/after 1/1	
PART A - INPATIENT HOSPITAL SERVICES UNDER PPS					
1.00	DRG Amounts Other than Outlier Payments		15,795,933		1.00
2.00	Outlier payments for discharges. (see instructions)		860,138		2.00
2.01	Outlier reconciliation amount		0		2.01
3.00	Managed Care Simulated Payments		0		3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		148.71		4.00
Indirect Medical Education Adjustment					
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00		5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00		6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(F)(1)(iv)(B)(1)		0.00		7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(F)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00		7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 Federal Register, page 50069, August 1, 2002.		0.00		8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00		8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00		8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00		9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00		10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00		11.00
12.00	Current year allowable FTE (see instructions)		0.00		12.00
13.00	Total allowable FTE count for the prior year.		0.00		13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00		14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00		15.00
16.00	Adjustment for residents in initial years of the program		0.00		16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00		17.00
18.00	Adjusted rolling average FTE count		0.00		18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000		19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000		20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000		21.00
22.00	IME payment adjustment (see instructions)		0		22.00
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA					
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (F)(1)(iv)(C).		0.00		23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00		24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00		25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000		26.00
27.00	IME payments adjustment. (see instructions)		0.000000		27.00
28.00	IME Adjustment (see instructions)		0		28.00
29.00	Total IME payment (sum of lines 22 and 28)		0		29.00
Disproportionate Share Adjustment					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		4.93		30.00
31.00	Percentage of Medicaid patient days (see instructions)		24.13		31.00
32.00	Sum of lines 30 and 31		29.06		32.00
33.00	Allowable disproportionate share percentage (see instructions)		13.19		33.00
34.00	Disproportionate share adjustment (see instructions)		2,083,484		34.00
Additional payment for high percentage of ESRD beneficiary discharges					
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		2,126		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	41.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150010	Period: From 07/01/2012 To 06/30/2013	Worksheet E Part A Date/Time Prepared: 11/26/2013 6:05 pm	
		Title XVIII	Hospital	PPS	
		0	before 1/1	on/after 1/1	
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41)		0		46.00
47.00	Subtotal (see instructions)		18,739,555		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0		48.00
49.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)		18,739,555		49.00
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)		1,363,532		50.00
51.00	Exception payment for inpatient program capital (Worksheet L, Part III, see instructions)		0		51.00
52.00	Direct graduate medical education payment (from Worksheet E-4, line 49 see instructions).		0		52.00
53.00	Nursing and Allied Health Managed Care payment		3,437		53.00
54.00	Special add-on payments for new technologies		11,076		54.00
55.00	Net organ acquisition cost (Worksheet D-4 Part III, col. 1, line 69)		0		55.00
56.00	Cost of teaching physicians (Worksheet D-5, Part II, col. 3, line 20)		0		56.00
57.00	Routine service other pass through costs (from Wkst D, Part III, column 9, lines 30-35).		0		57.00
58.00	Ancillary service other pass through costs Worksheet D, Part IV, col. 11 line 200)		31,347		58.00
59.00	Total (sum of amounts on lines 49 through 58)		20,148,947		59.00
60.00	Primary payer payments		0		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		20,148,947		61.00
62.00	Deductibles billed to program beneficiaries		1,828,191		62.00
63.00	Coinurance billed to program beneficiaries		46,089		63.00
64.00	Allowable bad debts (see instructions)		88,965		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		62,276		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		13,727		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		18,336,943		67.00
68.00	Credits received from manufacturers for replaced devices applicable to MS-DRG (see instructions)		0		68.00
69.00	Outlier payments reconciliation (Sum of lines 93, 95 and 96). (For SCH see instructions)		0		69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		70.00
70.92	Bundled Model 1 discount amount		0		70.92
70.93	HVBP incentive payment (see instructions)		17,595		70.93
70.94	Hospital readmissions reduction adjustment (see instructions)		0		70.94
70.95	Recovery of Accelerated Depreciation		0		70.95
70.96	Low Volume Payment-1 (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0		70.96
70.97	Low Volume Payment-2 (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0		70.97
70.98	Low Volume Payment-3		0		70.98
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		18,354,538		71.00
71.01	Sequestration adjustment (see instructions)		91,773		71.01
72.00	Interim payments		17,889,979		72.00
73.00	Tentative settlement (for contractor use only)		0		73.00
74.00	Balance due provider (Program) line 71 minus lines 71.01, 72 and 73		372,786		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		2,571,957		75.00
TO BE COMPLETED BY CONTRACTOR					
90.00	Operating outlier amount from Worksheet E, Part A line 2 (see instructions)		0		90.00
91.00	Capital outlier from Worksheet L, Part I, line 2		0		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0		92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0		93.00
94.00	The rate used to calculate the Time Value of Money		0.00		94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150010	Period: From 07/01/2012 To 06/30/2013	Worksheet E Part A Date/Time Prepared: 11/26/2013 6:05 pm	
		Title XVIII	Hospital	PPS	
			before 1/1	on/after 1/1	
		0	1.00	1.01	
95.00	Time Value of Money for operating expenses(see instructions)		0		95.00
96.00	Time Value of Money for capital related expenses (see instructions)		0		96.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150010	Period: From 07/01/2012 To 06/30/2013	Worksheet E Part B Date/Time Prepared: 11/26/2013 6:05 pm
		Title XVII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		7,570	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		14,264,508	2.00
3.00	PPS payments		10,686,513	3.00
4.00	Outlier payment (see instructions)		150,652	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.868	5.00
6.00	Line 2 times line 5		12,381,593	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		87.53	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		92,503	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		7,570	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		16,308	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)		16,308	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		16,308	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		8,738	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)		7,570	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		10,929,668	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		153	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		2,558,035	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)		8,379,050	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		8,379,050	30.00
31.00	Primary payer payments		2,143	31.00
32.00	Subtotal (line 30 minus line 31)		8,376,907	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Worksheet I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		177,775	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		124,443	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		80,105	36.00
37.00	Subtotal (see instructions)		8,501,350	37.00
38.00	MSP-LCC reconciliation amount from PS&R		-14	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		8,501,364	40.00
40.01	Sequestration adjustment (see instructions)		42,507	40.01
41.00	Interim payments		8,445,608	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		13,249	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 150010

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

Worksheet E-1
Part I
Date/Time Prepared:
11/26/2013 6:05 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		17,889,979		8,445,608	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		17,889,979		8,445,608	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		464,559		55,756	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		18,354,538		8,501,364	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 150010
Component CCN: 15T010

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

Worksheet E-1
Part I
Date/Time Prepared:
11/26/2013 6:05 pm
PPS

Title XVIII

Subprovider -
IRF

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider					1.00
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		3,930,844		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		3,930,844		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		5,851		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		3,936,695		0	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 FOR HIT		Provider CCN: 150010	Period: From 07/01/2012 To 06/30/2013	Worksheet E-1 Part II Date/Time Prepared: 11/26/2013 6:05 pm
		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14		5,206	1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12		9,667	2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6, line 2		914	3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12		20,118	4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200		379,798,281	5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20		7,251,227	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168		0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)		1,507,473	8.00
9.00	Sequestration adjustment amount (see instructions)		0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		1,507,473	10.00
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)		0	30.00
31.00	Other Adjustment (specify)		0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)		1,507,473	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150010 Component CCN: 15T010	Period: From 07/01/2012 To 06/30/2013	Worksheet E-3 Part III Date/Time Prepared: 11/26/2013 6:05 pm
		Title XVIIII	Subprovider - IRF	PPS
				1.00
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)			3,838,533 1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0173 2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			136,268 3.00
4.00	Outlier Payments			33,325 4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)			0.00 5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 5.01
6.00	New Teaching program adjustment. (see instructions)			0.00 6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program". (see inst.)			0.00 7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program". (see inst.)			0.00 8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)			0.00 9.00
10.00	Average Daily Census (see instructions)			12.065753 10.00
11.00	Indirect Medical Education Adjustment Factor $\{((1 + (\text{line } 9/\text{line } 10)) \text{ raised to the power of } .6876 - 1)\}$.			0.000000 11.00
12.00	Indirect Medical Education Adjustment (line 1 multiplied by line 11).			0 12.00
13.00	Total PPS Payment (sum of lines 1, 3, 4 and 12)			4,008,126 13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)			0 14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)			0 15.00
16.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)			0 16.00
17.00	Subtotal (see instructions)			4,008,126 17.00
18.00	Primary payer payments			0 18.00
19.00	Subtotal (line 17 less line 18).			4,008,126 19.00
20.00	Deductibles			50,212 20.00
21.00	Subtotal (line 19 minus line 20)			3,957,914 21.00
22.00	Coinurance			25,176 22.00
23.00	Subtotal (line 21 minus line 22)			3,932,738 23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			3,744 24.00
25.00	Adjusted reimbursable bad debts (see instructions)			2,621 25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			1,156 26.00
27.00	Subtotal (sum of lines 23 and 25)			3,935,359 27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 49)			0 28.00
29.00	Other pass through costs (see instructions)			1,336 29.00
30.00	Outlier payments reconciliation			0 30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 31.00
31.99	Recovery of Accelerated Depreciation			0 31.99
32.00	Total amount payable to the provider (see instructions)			3,936,695 32.00
32.01	Sequestration adjustment (see instructions)			19,683 32.01
33.00	Interim payments			3,930,844 33.00
34.00	Tentative settlement (for contractor use only)			0 34.00
35.00	Balance due provider/program line 32 minus lines 32.01, 33 and 34			-13,832 35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2			197,385 36.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part III, line 4			33,325 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150010	Period: From 07/01/2012 To 06/30/2013	Worksheet E-3 Part VII Date/Time Prepared: 11/26/2013 6:05 pm	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		2,804,108		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)		2,804,108	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)		2,804,108	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		2,013,807		8.00
9.00	Ancillary service charges		4,476,772	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)		6,490,579	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		6,490,579	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		3,686,471	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of Teaching Physicians (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		2,804,108	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		2,804,108	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		2,804,108	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)		2,804,108	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		37.00
38.00	Subtotal (line 36 ± line 37)		2,804,108	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)		2,804,108	0	40.00
41.00	Interim payments		2,804,108	0	41.00
42.00	Balance due provider/program (line 40 minus 41)		0		42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 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: 150010

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

Worksheet G

Date/Time Prepared:
11/26/2013 6:05 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	274,617	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	43,065,121	0	0	0	4.00
5.00	Other receivable	437,294	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-23,423,147	0	0	0	6.00
7.00	Inventory	2,307,072	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	1,188,325	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)	23,849,282	0	0	0	11.00
FIXED ASSETS						
12.00	Land	722,779	0	0	0	12.00
13.00	Land improvements	2,293,313	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	67,622,890	0	0	0	15.00
16.00	Accumulated depreciation	-53,007,579	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	70,832,860	0	0	0	19.00
20.00	Accumulated depreciation	-55,432,287	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	0	0	0	0	23.00
24.00	Accumulated depreciation	0	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)	33,031,976	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	142,877,112	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	308,778	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	143,185,890	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	200,067,148	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	3,341,298	0	0	0	37.00
38.00	Salaries, wages, and fees payable	5,865,636	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	241,917	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	7,930,927	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	17,379,778	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	16,564,057	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	2,344,613	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	18,908,670	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	36,288,448	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	163,778,700				52.00
53.00	Specific purpose fund		0			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)	163,778,700	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	200,067,148	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 150010

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

Worksheet G-1

Date/Time Prepared:
11/26/2013 6:05 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		146,358,545			0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		23,128,536				2.00
3.00	Total (sum of line 1 and line 2)		169,487,081			0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0			0	10.00
11.00	Subtotal (line 3 plus line 10)		169,487,081			0	11.00
12.00	ADJUSTMENTS	5,708,381		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		5,708,381			0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		163,778,700			0	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	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	ADJUSTMENTS		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 150010

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
11/26/2013 6:05 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	23,982,258		23,982,258	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	5,334,089		5,334,089	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)	29,316,347		29,316,347	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	5,758,762		5,758,762	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)	5,758,762		5,758,762	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	35,075,109		35,075,109	17.00
18.00	Ancillary services	125,700,830		125,700,830	18.00
19.00	Outpatient services	0	213,706,657	213,706,657	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	63,011	5,252,675	5,315,686	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)	160,838,950	218,959,332	379,798,282	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		109,551,072		29.00
30.00		0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00		0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		109,551,072		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 150010

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

Worksheet G-3

Date/Time Prepared:
11/26/2013 6:05 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	379,798,282	1.00
2.00	Less contractual allowances and discounts on patients' accounts	255,232,802	2.00
3.00	Net patient revenues (line 1 minus line 2)	124,565,480	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	109,551,072	4.00
5.00	Net income from service to patients (line 3 minus line 4)	15,014,408	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	585,857	6.00
7.00	Income from investments	5,741,203	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	30,117	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	442,873	22.00
23.00	Governmental appropriations	0	23.00
24.00	UNREALIZED GAIN	4,231,437	24.00
24.01	LOSS FROM UNSOLIDATED ENTITIES	-48,724	24.01
24.02	OTHER NON-OPERATING LOSS	-3,573	24.02
24.03	OTHER MISCELLANEOUS REVENUE	-2,624,225	24.03
24.04	GAIN ON SALE OF OTHER ASSETS	33,357	24.04
24.05	NET ASSETS RELEASED FROM RESTRICTION	43,040	24.05
24.06	MISC	-1	24.06
25.00	Total other income (sum of lines 6-24)	8,431,361	25.00
26.00	Total (line 5 plus line 25)	23,445,769	26.00
27.00	TOTAL NON-RECURRING EXPENSES	317,233	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	317,233	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	23,128,536	29.00

CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B		Provider CCN: 150010	Period: From 07/01/2012 To 06/30/2013	Worksheet I-5 Date/Time Prepared: 11/26/2013 6:05 pm
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		1.00	2.00	
PART I - CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART 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)	0	0	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)	0	0	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	0	0	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			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			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)	0	0	10.00
11.00	Reimbursable bad debts (see instructions) (transfer to Worksheet E, Part B, line 33)	0		11.00
PART II - CALCULATION OF FACILITY SPECIFIC COMPOSITE COST PERCENTAGE				
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

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 150010	Period: From 07/01/2012 To 06/30/2013	Worksheet L Parts I-III Date/Time Prepared: 11/26/2013 6:05 pm
		Title XVIII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		1,247,158	1.00
2.00	Capital DRG outlier payments		40,796	2.00
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		55.12	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (line 1 times line 5)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		4.93	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		24.13	8.00
9.00	Sum of lines 7 and 8		29.06	9.00
10.00	Allowable disproportionate share percentage (see instructions)		6.06	10.00
11.00	Disproportionate share adjustment (line 1 times line 10)		75,578	11.00
12.00	Total prospective capital payments (sum of lines 1-2, 6, and 11)		1,363,532	12.00
				1.00
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
				1.00
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00