This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

FORM APPROVED
OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 150153	Period: From 07/01/2013 To 06/30/2014	Worksheet S Parts I-III Date/Time Prepared: 11/25/2014 8:46 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 11/25/2014 Time: 8:46 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. [1] 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. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST. VINCENT HEART CENTER (150153) for the cost reporting period beginning 07/01/2013 and ending 06/30/2014 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	10,175	10,845	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	10,175	10,845	0	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents , please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 150153 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-2 Part I | Date/Time Prepared: 11/24/2014 5:24 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 10580 N. MERIDIAN ST.	PO Box:			1.00
2.00	City: INDIANAPOLIS	State: IN	Zip Code: 46290	County: HAMILTON	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	ST. VINCENT HEART CENTER	150153	26900	1	12/05/2002	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2013	06/30/2014	20.00
21.00	Type of Control (see instructions)	4		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)			22.01
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	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.	409	0	0	0	145	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.	0	0	0	0	0		25.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 150153 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-2 Part I Date/Time Prepared: 11/24/2014 5:24 pm

		Beginning:	Ending:	
		1.00	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	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)			39.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	Y	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.10

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 150153 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-2 Part I Date/Time Prepared: 11/24/2014 5:24 pm

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.20

		1.00	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)		
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00	62.01
	Teaching Hospitals that Claim Residents in Non-Provider Settings		
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)	N	63.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	64.00

		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	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010				
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 150153 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-2 Part I | Date/Time Prepared: 11/24/2014 5:24 pm

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1 the program name associated with each of your primary care programs in which you trained residents. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			0	76.00

		1.00	
	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 150153	Period: From 07/01/2013 To 06/30/2014	Worksheet S-2 Part I Date/Time Prepared: 11/24/2014 5:24 pm

		V	XIX	
		1.00	2.00	
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I &R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					109.00

		1.00	2.00	3.00	
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	29,304	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost 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	15HO46	140.00

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	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: ST. VINCENT HEALTH	Contractor's Name: WPS	Contractor's Number: 08101	141.00
142.00	Street: 10330 N. MERIDIAN ST	PO Box:		142.00
143.00	City: INDIANAPOLIS	State: IN	Zip Code: 46290	143.00

		1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y	144.00
145.00	If costs for renal services are claimed on Worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.	Y	145.00

		1.00	2.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N		147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N		148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N		149.00

		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00

		1.00	
	Multicampus		
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N	165.00

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.	N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 150153 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-2 Part II | Date/Time Prepared: 11/24/2014 5:24 pm

		Y/N	Date	
		1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.			
	COMPLETED BY ALL HOSPITALS			
	Provider Organization and Operation			
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N		9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14.00
	Bed Complement		
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15.00

			Part A		Part B	
		Description	Y/N	Date	Y/N	
		0	1.00	2.00	3.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		Y	10/10/2014	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 150153 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-2 Part II Date/Time Prepared: 11/24/2014 5:24 pm

		Description	Part A Y/N	Part A Date	Part B Y/N	
		0	1.00	2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		N	21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	JILL	HILL	41.00
42.00	Enter the employer/company name of the cost report preparer.	ST. VINCENT HEALTH		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(317) 583-3232	JILL.HILL@STVINCENT.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 150153 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-2 Part II | Date/Time Prepared: 11/24/2014 5:24 pm

		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)	10/10/2014			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)				17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.				18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.				19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:				20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.				21.00
			3.00		
	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: 150153 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-3 Part I Date/Time Prepared: 11/24/2014 5:24 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	107	39,055	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		107	39,055	0.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		107	39,055	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		107				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 150153 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-3 Part I | Date/Time Prepared: 11/24/2014 5:24 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)	10,313	409	18,265			1.00
2.00	HMO and other (see instructions)	2,133	145				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	10,313	409	18,265			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)	10,313	409	18,265	0.00	410.17	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	410.17	27.00
28.00	Observation Bed Days		0	1,573			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 150153 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-3 Part I | Date/Time Prepared: 11/24/2014 5:24 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
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	2,349	95	4,378	1.00
2.00	HMO and other (see instructions)			492	38		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	2,349	95	4,378	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 150153 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-3 Part II Date/Time Prepared: 11/24/2014 5:24 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	28,145,991	0	28,145,991	853,151.00	32.99	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		0	0	0	0.00	0.00	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		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		0	0	0	0.00	0.00	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		81,978	0	81,978	1,293.00	63.40	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00	13.00
14.00	Home office salaries & wage-related costs		5,079,635	0	5,079,635	106,321.00	47.78	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)		8,304,231	0	8,304,231			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		0	0	0			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/FQHC)		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	353,457	0	353,457	7,757.00	45.57	26.00
27.00	Administrative & General	5.00	4,097,170	0	4,097,170	138,458.00	29.59	27.00
28.00	Administrative & General under contract (see inst.)		64,298	0	64,298	1,842.00	34.91	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	485,572	0	485,572	16,530.00	29.38	30.00
31.00	Laundry & Linen Service	8.00	31,241	0	31,241	2,617.00	11.94	31.00
32.00	Housekeeping	9.00	0	0	0	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)		688,643	0	688,643	36,728.00	18.75	33.00
34.00	Dietary	10.00	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		268,473	0	268,473	14,631.00	18.35	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	957,625	0	957,625	22,946.00	41.73	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	1,591,923	0	1,591,923	37,371.00	42.60	40.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 150153 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-3 Part II Date/Time Prepared: 11/24/2014 5:24 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	
41.00	Medical Records & Medical Records Library	16.00	1,681,159	0	1,681,159	48,282.00	34.82	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 150153 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-3 Part III Date/Time Prepared: 11/24/2014 5:24 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 III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		29,167,405	0	29,167,405	906,352.00	32.18	1.00
2.00	Excluded area salaries (see instructions)		0	0	0	0.00	0.00	2.00
3.00	Subtotal salaries (line 1 minus line 2)		29,167,405	0	29,167,405	906,352.00	32.18	3.00
4.00	Subtotal other wages & related costs (see inst.)		5,161,613	0	5,161,613	107,614.00	47.96	4.00
5.00	Subtotal wage-related costs (see inst.)		8,304,231	0	8,304,231	0.00	28.47	5.00
6.00	Total (sum of lines 3 thru 5)		42,633,249	0	42,633,249	1,013,966.00	42.05	6.00
7.00	Total overhead cost (see instructions)		10,219,561	0	10,219,561	327,162.00	31.24	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 150153 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-3 Part IV Date/Time Prepared: 11/24/2014 5:24 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	1,309,314	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	3,623,586	8.00
9.00	Prescription Drug Plan	719,387	9.00
10.00	Dental, Hearing and Vision Plan	24,125	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	21,594	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	1,601	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	125,547	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	5,384	14.00
15.00	'Workers' Compensation Insurance	418,321	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	1,956,939	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	64,575	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	33,858	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	8,304,231	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 150153 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-3 Part V Date/Time Prepared: 11/24/2014 5:24 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	81,978	8,304,231	1.00
2.00	Hospital	81,978	8,304,231	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 150153 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-10 | Date/Time Prepared: 11/24/2014 5:24 pm

		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)	0.230425	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	328,192	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	14,443,967	6.00
7.00	Medicaid cost (line 1 times line 6)	3,328,251	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	3,000,059	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	17,391	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	3,000,059	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	12,117,294	318,353	12,435,647	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	2,792,127	73,356	2,865,483	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	2,792,127	73,356	2,865,483	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?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	2,944,816	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	138,555	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	2,806,261	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	646,633	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	3,512,116	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	6,512,175	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 150153 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A | Date/Time Prepared: 11/24/2014 5:24 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		2,443,688	2,443,688	1,526,755	3,970,443	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2,986,383	2,986,383	412,819	3,399,202	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	353,457	8,450,849	8,804,306	0	8,804,306	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,097,170	18,244,764	22,341,934	-1,939,574	20,402,360	5.00
7.00	00700	OPERATION OF PLANT	485,572	3,884,017	4,369,589	0	4,369,589	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	31,241	394,204	425,445	0	425,445	8.00
9.00	00900	HOUSEKEEPING	0	827,406	827,406	0	827,406	9.00
10.00	01000	DIETARY	0	1,712,463	1,712,463	-1,320,188	392,275	10.00
11.00	01100	CAFETERIA	0	0	0	1,320,188	1,320,188	11.00
13.00	01300	NURSING ADMINISTRATION	957,625	117,336	1,074,961	0	1,074,961	13.00
15.00	01500	PHARMACY	1,591,923	-18,438	1,573,485	0	1,573,485	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,681,159	460,792	2,141,951	0	2,141,951	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,561,585	435,242	10,996,827	0	10,996,827	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,366,006	270,607	3,636,613	0	3,636,613	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	456,915	424,787	881,702	0	881,702	54.00
57.00	05700	CT SCAN	257,612	132,813	390,425	0	390,425	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	229,870	19,849	249,719	0	249,719	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,474,406	174,996	1,649,402	0	1,649,402	59.00
60.00	06000	LABORATORY	0	2,410,432	2,410,432	0	2,410,432	60.00
65.00	06500	RESPIRATORY THERAPY	1,109,763	47,230	1,156,993	0	1,156,993	65.00
66.00	06600	PHYSICAL THERAPY	319,984	5,832	325,816	0	325,816	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	10,884,960	10,884,960	0	10,884,960	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	18,143,931	18,143,931	0	18,143,931	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,909,120	2,909,120	0	2,909,120	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,171,703	915,832	2,087,535	0	2,087,535	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	28,145,991	76,279,095	104,425,086	0	104,425,086	118.00
		NONREIMBURSABLE COST CENTERS						
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MARKETING	0	1,325,739	1,325,739	0	1,325,739	193.01
200.00		TOTAL (SUM OF LINES 118-199)	28,145,991	77,604,834	105,750,825	0	105,750,825	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 150153 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A | Date/Time Prepared: 11/24/2014 5:24 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	-1,409,449	2,560,994		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-67,292	3,331,910		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-991,424	7,812,882		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-5,015,299	15,387,061		5.00
7.00	00700	OPERATION OF PLANT	-69	4,369,520		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	425,445		8.00
9.00	00900	HOUSEKEEPING	0	827,406		9.00
10.00	01000	DIETARY	0	392,275		10.00
11.00	01100	CAFETERIA	-457,484	862,704		11.00
13.00	01300	NURSING ADMINISTRATION	0	1,074,961		13.00
15.00	01500	PHARMACY	0	1,573,485		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-14,312	2,127,639		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	10,996,827		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-965,206	2,671,407		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-106,950	774,752		54.00
57.00	05700	CT SCAN	0	390,425		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	249,719		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,649,402		59.00
60.00	06000	LABORATORY	0	2,410,432		60.00
65.00	06500	RESPIRATORY THERAPY	0	1,156,993		65.00
66.00	06600	PHYSICAL THERAPY	0	325,816		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	10,884,960		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	18,143,931		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,909,120		73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	-900,239	1,187,296		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	-9,927,724	94,497,362		118.00
		NONREIMBURSABLE COST CENTERS				
193.00	19300	NONPAID WORKERS	0	0		193.00
193.01	19301	MARKETING	1,480,096	2,805,835		193.01
200.00		TOTAL (SUM OF LINES 118-199)	-8,447,628	97,303,197		200.00

RECLASSIFICATIONS | Provider CCN: 150153 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-6 | Date/Time Prepared: 11/24/2014 5:24 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAPITAL					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,264,895		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	314,425		2.00
3.00	CAP REL COSTS-BLDG & FIXT	1.00	0	40,394		3.00
4.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	15,178		4.00
5.00	CAP REL COSTS-BLDG & FIXT	1.00	0	221,466		5.00
6.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	83,216		6.00
	TOTALS		0	1,939,574		
	B - CAFETERIA					
1.00	CAFETERIA	11.00	0	1,320,188		1.00
	TOTALS		0	1,320,188		
500.00	Grand Total: Increases		0	3,259,762		500.00

RECLASSIFICATIONS | Provider CCN: 150153 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-6 | Date/Time Prepared: 11/24/2014 5:24 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAPITAL						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,264,895	11		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	314,425	11		2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	0	40,394	12		3.00
4.00	ADMINISTRATIVE & GENERAL	5.00	0	15,178	12		4.00
5.00	ADMINISTRATIVE & GENERAL	5.00	0	221,466	13		5.00
6.00	ADMINISTRATIVE & GENERAL	5.00	0	83,216	13		6.00
	TOTALS		0	1,939,574			
	B - CAFETERIA						
1.00	DIETARY	10.00	0	1,320,188	0		1.00
	TOTALS		0	1,320,188			
500.00	Grand Total: Decreases		0	3,259,762			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 150153 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-7 Part I | Date/Time Prepared: 11/24/2014 5:24 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	42,301,141	1,514,982	0	1,514,982	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	6,258,340	0	0	0	0	5.00
6.00	Movable Equipment	17,281,557	1,533,804	0	1,533,804	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	65,841,038	3,048,786	0	3,048,786	0	8.00
9.00	Reconciling Items	54,521	1,183,913	0	1,183,913	0	9.00
10.00	Total (line 8 minus line 9)	65,786,517	1,864,873	0	1,864,873	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	0	0	1.00
2.00	Land Improvements	0	0	2.00
3.00	Buildings and Fixtures	43,816,123	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	6,258,340	0	5.00
6.00	Movable Equipment	18,815,361	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	68,889,824	0	8.00
9.00	Reconciling Items	1,238,434	0	9.00
10.00	Total (line 8 minus line 9)	67,651,390	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 150153 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-7 Part II | Date/Time Prepared: 11/24/2014 5:24 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,763,715	679,973	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,893,925	1,092,458	0	0	0	2.00
3.00	Total (sum of lines 1-2)	3,657,640	1,772,431	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	2,443,688	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,986,383	2.00
3.00	Total (sum of lines 1-2)	0	5,430,071	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 150153 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-7 Part III Date/Time Prepared: 11/24/2014 5:24 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: 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	50,074,463	0	50,074,463	0.726877	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	18,815,361	0	18,815,361	0.273123	0	2.00
3.00	Total (sum of lines 1-2)	68,889,824	0	68,889,824	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: 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	1,763,715	52,078	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,893,925	1,092,458	2.00
3.00	Total (sum of lines 1-2)	0	0	0	3,657,640	1,144,536	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: 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	483,341	40,394	221,466	0	2,560,994	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	247,133	15,178	83,216	0	3,331,910	2.00
3.00	Total (sum of lines 1-2)	730,474	55,572	304,682	0	5,892,904	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 150153 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-8 | Date/Time Prepared: 11/24/2014 5:24 pm

	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)	B	-270,707	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-67,292	CAP REL COSTS-MVBLE EQUIP	2.00	11	2.00
3.00	Investment income - other (chapter 2)	B	-45,960	ADMINISTRATIVE & GENERAL	5.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,972,395			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	-293,971			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-457,484	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-14,312	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	SPONSORSHIPS/DONATIONS	A	-29,589	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	OTHER NON-REIMBURSABLE EXPENSE	A	-1,158	ADMINISTRATIVE & GENERAL	5.00	0	33.01

ADJUSTMENTS TO EXPENSES | Provider CCN: 150153 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-8 | Date/Time Prepared: 11/24/2014 5:24 pm

	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	
33.02	OTHER NON-REIMBURSABLE EXPENSE	A	-56	OPERATION OF PLANT	7.00	0	33.02
33.03	LOBBYING DUES	A	-1,491	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	PROVIDER ASSESSMENT TAX	A	-2,990,405	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	PURCHASE DISCOUNTS	A	-2,302,808	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06			0		0.00	0	33.06
33.07			0		0.00	0	33.07
33.08			0		0.00	0	33.08
33.09			0		0.00	0	33.09
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-8,447,628				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 150153 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-8-1 | Date/Time Prepared: 11/24/2014 5:24 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	CHARGEBACKS	1,264,820	1,264,820	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	CHARGEBACKS	314,501	314,501	2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	CHARGEBACKS	1,939,626	1,939,626	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	CHARGEBACKS	13,630,857	13,630,857	4.00
4.01	7.00	OPERATION OF PLANT	CHARGEBACKS	174,367	174,367	4.01
4.02	13.00	NURSING ADMINISTRATION	CHARGEBACKS	385	385	4.02
4.03	15.00	PHARMACY	CHARGEBACKS	7,752	7,752	4.03
4.04	16.00	MEDICAL RECORDS & LIBRARY	CHARGEBACKS	137,592	137,592	4.04
4.05	30.00	ADULTS & PEDIATRICS	CHARGEBACKS	550	550	4.05
4.06	50.00	OPERATING ROOM	CHARGEBACKS	2,053,571	2,053,571	4.06
4.07	54.00	RADIOLOGY-DIAGNOSTIC	CHARGEBACKS	484,899	484,899	4.07
4.08	59.00	CARDIAC CATHETERIZATION	CHARGEBACKS	500	500	4.08
4.09	65.00	RESPIRATORY THERAPY	CHARGEBACKS	78,330	78,330	4.09
4.10	66.00	PHYSICAL THERAPY	CHARGEBACKS	190,274	190,274	4.10
4.11	91.00	EMERGENCY	CHARGEBACKS	350	350	4.11
4.12	193.01	MARKETING	CHARGEBACKS	1,323,060	1,323,060	4.12
4.13	1.00	CAP REL COSTS-BLDG & FIXT	CIHC NEWCO-RENT	25,579	653,474	4.13
4.14	4.00	EMPLOYEE BENEFITS DEPARTMENT	ASCENSION PENSION	148,158	148,158	4.14
4.15	4.00	EMPLOYEE BENEFITS DEPARTMENT	SELF INSURANCE	2,651,228	3,642,652	4.15
4.16	7.00	OPERATION OF PLANT	TRIMEDX	1,955	1,968	4.16
4.17	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	472,450	60,000	4.17
4.18	193.01	MARKETING	HOME OFFICE	1,480,096	0	4.18
4.19	1.00	CAP REL COSTS-BLDG & FIXT	ASCENSION INTEREST	783,192	1,294,039	4.19
4.20	5.00	ADMINISTRATIVE & GENERAL	ASCENSION INTEREST	86,373	142,711	4.20
5.00	0		0	27,250,465	27,544,436	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		
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					
6.00	B		0.00	ST. VINCENT HOS	0.00	6.00
7.00	B		74.08	ST. VINCENT HEA	0.00	7.00
8.00	B		0.00	CIHS NEWCO	0.00	8.00
9.00	B		100.00	ASCENSION	0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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.

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 150153	Period: From 07/01/2013 To 06/30/2014	Worksheet A-8-1 Date/Time Prepared: 11/24/2014 5:24 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	0	9		1.00
2.00	0	9		2.00
3.00	0	0		3.00
4.00	0	0		4.00
4.01	0	0		4.01
4.02	0	0		4.02
4.03	0	0		4.03
4.04	0	0		4.04
4.05	0	0		4.05
4.06	0	0		4.06
4.07	0	0		4.07
4.08	0	0		4.08
4.09	0	0		4.09
4.10	0	0		4.10
4.11	0	0		4.11
4.12	0	0		4.12
4.13	-627,895	10		4.13
4.14	0	0		4.14
4.15	-991,424	0		4.15
4.16	-13	0		4.16
4.17	412,450	0		4.17
4.18	1,480,096	0		4.18
4.19	-510,847	11		4.19
4.20	-56,338	0		4.20
5.00	-293,971			5.00

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

	Related Organization(s) and/or Home Office		
	Type of Business		
	6.00		
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:		

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

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

6.00	HEALTH SVCS		6.00
7.00	HEALTH MGMT		7.00
8.00	PROPERTY MGMT		8.00
9.00	HEALTH MGMT		9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 150153 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-8-2 | Date/Time Prepared: 11/24/2014 5:24 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	50.00	OPERATING ROOM	962,956	962,956	0	0	0	1.00
2.00	50.00	OPERATING ROOM	2,250	2,250	0	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	106,950	106,950	0	0	0	3.00
4.00	91.00	EMERGENCY	900,239	900,239	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,972,395	1,972,395	0		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	50.00	OPERATING ROOM	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	50.00	OPERATING ROOM	0	0	0	962,956		1.00
2.00	50.00	OPERATING ROOM	0	0	0	2,250		2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	106,950		3.00
4.00	91.00	EMERGENCY	0	0	0	900,239		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,972,395		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150153 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part I Date/Time Prepared: 11/24/2014 5:24 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,560,994	2,560,994				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	3,331,910		3,331,910			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	7,812,882	8,966	11,664	7,833,512		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	15,387,061	179,811	233,938	1,154,816	16,955,626	5.00
7.00	00700	OPERATION OF PLANT	4,369,520	453,327	589,788	136,862	5,549,497	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	425,445	34,087	44,348	8,805	512,685	8.00
9.00	00900	HOUSEKEEPING	827,406	72,407	94,203	0	994,016	9.00
10.00	01000	DIETARY	392,275	55,318	71,969	0	519,562	10.00
11.00	01100	CAFETERIA	862,704	54,362	70,726	0	987,792	11.00
13.00	01300	NURSING ADMINISTRATION	1,074,961	57,070	74,249	269,913	1,476,193	13.00
15.00	01500	PHARMACY	1,573,485	58,162	75,670	448,695	2,156,012	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,127,639	59,368	77,239	473,846	2,738,092	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,996,827	892,476	1,161,133	2,976,849	16,027,285	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,671,407	250,943	326,483	948,732	4,197,565	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	774,752	22,573	29,368	128,785	955,478	54.00
57.00	05700	CT SCAN	390,425	13,494	17,556	72,610	494,085	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	249,719	14,199	18,473	64,790	347,181	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,649,402	142,674	185,623	415,572	2,393,271	59.00
60.00	06000	LABORATORY	2,410,432	32,403	42,157	0	2,484,992	60.00
65.00	06500	RESPIRATORY THERAPY	1,156,993	82,851	107,791	312,794	1,660,429	65.00
66.00	06600	PHYSICAL THERAPY	325,816	0	0	90,190	416,006	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	10,884,960	0	0	0	10,884,960	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	18,143,931	0	0	0	18,143,931	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,909,120	0	0	0	2,909,120	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,187,296	76,503	99,532	330,253	1,693,584	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	94,497,362	2,560,994	3,331,910	7,833,512	94,497,362	118.00
		NONREIMBURSABLE COST CENTERS						
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MARKETING	2,805,835	0	0	0	2,805,835	193.01
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	97,303,197	2,560,994	3,331,910	7,833,512	97,303,197	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150153 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part I Date/Time Prepared: 11/24/2014 5:24 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	16,955,626					5.00
7.00	00700	OPERATION OF PLANT	1,171,099	6,720,596				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	108,191	119,384	740,260			8.00
9.00	00900	HOUSEKEEPING	209,765	253,592	0	1,457,373		9.00
10.00	01000	DIETARY	109,642	193,741	0	44,482	867,427	10.00
11.00	01100	CAFETERIA	208,452	190,394	0	43,713	0	11.00
13.00	01300	NURSING ADMINISTRATION	311,518	199,877	0	45,891	0	13.00
15.00	01500	PHARMACY	454,979	203,703	0	46,769	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	577,814	207,927	0	47,739	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,382,206	3,125,753	462,662	717,651	857,852	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	885,804	878,886	71,179	201,787	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	201,633	79,058	0	18,151	0	54.00
57.00	05700	CT SCAN	104,266	47,260	0	10,851	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	73,265	49,730	49,825	11,418	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	505,047	499,693	49,825	114,726	0	59.00
60.00	06000	LABORATORY	524,403	113,487	0	26,056	0	60.00
65.00	06500	RESPIRATORY THERAPY	350,397	290,173	35,590	66,622	606	65.00
66.00	06600	PHYSICAL THERAPY	87,789	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,297,031	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,828,915	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	613,906	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	357,394	267,938	71,179	61,517	8,969	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	16,363,516	6,720,596	740,260	1,457,373	867,427	118.00
		NONREIMBURSABLE COST CENTERS						
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MARKETING	592,110	0	0	0	0	193.01
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)	16,955,626	6,720,596	740,260	1,457,373	867,427	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150153 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part I Date/Time Prepared: 11/24/2014 5:24 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
			11.00	13.00	15.00	16.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	1,430,351					11.00
13.00	01300	NURSING ADMINISTRATION	47,719	2,081,198				13.00
15.00	01500	PHARMACY	0	0	2,861,463			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	100,409	151,140	0	3,823,121		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	740,643	1,114,849	0	654,502	27,083,403	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	153,521	231,087	0	389,787	7,009,616	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	28,285	42,576	0	164,759	1,489,940	54.00
57.00	05700	CT SCAN	15,579	23,450	0	36,335	731,826	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	12,960	19,508	0	14,395	578,282	58.00
59.00	05900	CARDIAC CATHETERIZATION	81,857	123,214	0	1,153,614	4,921,247	59.00
60.00	06000	LABORATORY	0	0	0	235,364	3,384,302	60.00
65.00	06500	RESPIRATORY THERAPY	75,684	113,923	0	110,233	2,703,657	65.00
66.00	06600	PHYSICAL THERAPY	19,416	29,225	0	18,092	570,528	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	253,210	13,435,201	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	429,339	22,402,185	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	77,718	116,985	2,861,463	294,511	6,873,703	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	76,560	115,241	0	68,980	2,721,362	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,430,351	2,081,198	2,861,463	3,823,121	93,905,252	118.00
		NONREIMBURSABLE COST CENTERS						
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MARKETING	0	0	0	0	3,397,945	193.01
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)	1,430,351	2,081,198	2,861,463	3,823,121	97,303,197	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150153 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part I | Date/Time Prepared: 11/24/2014 5:24 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	27,083,403		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	7,009,616		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,489,940		54.00
57.00	05700	CT SCAN	0	731,826		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	578,282		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	4,921,247		59.00
60.00	06000	LABORATORY	0	3,384,302		60.00
65.00	06500	RESPIRATORY THERAPY	0	2,703,657		65.00
66.00	06600	PHYSICAL THERAPY	0	570,528		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	13,435,201		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	22,402,185		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,873,703		73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	2,721,362		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	93,905,252		118.00
		NONREIMBURSABLE COST CENTERS				
193.00	19300	NONPAID WORKERS	0	0		193.00
193.01	19301	MARKETING	0	3,397,945		193.01
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118-201)	0	97,303,197		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150153 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part II Date/Time Prepared: 11/24/2014 5:24 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	8,966	11,664	20,630	20,630	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,699,152	179,811	233,938	2,112,901	3,040	5.00
7.00	00700	OPERATION OF PLANT	0	453,327	589,788	1,043,115	360	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	34,087	44,348	78,435	23	8.00
9.00	00900	HOUSEKEEPING	0	72,407	94,203	166,610	0	9.00
10.00	01000	DIETARY	0	55,318	71,969	127,287	0	10.00
11.00	01100	CAFETERIA	0	54,362	70,726	125,088	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	57,070	74,249	131,319	711	13.00
15.00	01500	PHARMACY	0	58,162	75,670	133,832	1,181	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	59,368	77,239	136,607	1,247	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	892,476	1,161,133	2,053,609	7,846	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	250,943	326,483	577,426	2,498	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	22,573	29,368	51,941	339	54.00
57.00	05700	CT SCAN	0	13,494	17,556	31,050	191	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	14,199	18,473	32,672	171	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	142,674	185,623	328,297	1,094	59.00
60.00	06000	LABORATORY	0	32,403	42,157	74,560	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	82,851	107,791	190,642	823	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	237	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	76,503	99,532	176,035	869	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,699,152	2,560,994	3,331,910	7,592,056	20,630	118.00
		NONREIMBURSABLE COST CENTERS						
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MARKETING	0	0	0	0	0	193.01
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,699,152	2,560,994	3,331,910	7,592,056	20,630	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150153 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part II Date/Time Prepared: 11/24/2014 5:24 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,115,941					5.00
7.00	00700	OPERATION OF PLANT	146,146	1,189,621				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	13,502	21,132	113,092			8.00
9.00	00900	HOUSEKEEPING	26,177	44,889	0	237,676		9.00
10.00	01000	DIETARY	13,683	34,294	0	7,254	182,518	10.00
11.00	01100	CAFETERIA	26,014	33,702	0	7,129	0	11.00
13.00	01300	NURSING ADMINISTRATION	38,876	35,381	0	7,484	0	13.00
15.00	01500	PHARMACY	56,779	36,058	0	7,627	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	72,108	36,805	0	7,785	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	422,079	553,294	70,683	117,041	180,504	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	110,543	155,573	10,874	32,908	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	25,163	13,994	0	2,960	0	54.00
57.00	05700	CT SCAN	13,012	8,365	0	1,770	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	9,143	8,803	7,612	1,862	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	63,027	88,451	7,612	18,710	0	59.00
60.00	06000	LABORATORY	65,442	20,088	0	4,249	0	60.00
65.00	06500	RESPIRATORY THERAPY	43,727	51,364	5,437	10,865	127	65.00
66.00	06600	PHYSICAL THERAPY	10,956	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	286,655	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	477,804	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	76,612	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	44,601	47,428	10,874	10,032	1,887	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,042,049	1,189,621	113,092	237,676	182,518	118.00
		NONREIMBURSABLE COST CENTERS						
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MARKETING	73,892	0	0	0	0	193.01
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)	2,115,941	1,189,621	113,092	237,676	182,518	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150153 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part II Date/Time Prepared: 11/24/2014 5:24 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
			11.00	13.00	15.00	16.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	191,933					11.00
13.00	01300	NURSING ADMINISTRATION	6,403	220,174				13.00
15.00	01500	PHARMACY	0	0	235,477			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	13,473	15,989	0	284,014		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	99,386	117,942	0	48,629	3,671,013	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	20,600	24,447	0	28,961	963,830	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,795	4,504	0	12,241	114,937	54.00
57.00	05700	CT SCAN	2,090	2,481	0	2,700	61,659	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,739	2,064	0	1,070	65,136	58.00
59.00	05900	CARDIAC CATHETERIZATION	10,984	13,035	0	85,673	616,883	59.00
60.00	06000	LABORATORY	0	0	0	17,487	181,826	60.00
65.00	06500	RESPIRATORY THERAPY	10,156	12,052	0	8,190	333,383	65.00
66.00	06600	PHYSICAL THERAPY	2,605	3,092	0	1,344	18,234	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	18,813	305,468	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	31,899	509,703	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,429	12,376	235,477	21,882	356,776	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	10,273	12,192	0	5,125	319,316	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	191,933	220,174	235,477	284,014	7,518,164	118.00
		NONREIMBURSABLE COST CENTERS						
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MARKETING	0	0	0	0	73,892	193.01
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)	191,933	220,174	235,477	284,014	7,592,056	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150153 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part II | Date/Time Prepared: 11/24/2014 5:24 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	3,671,013		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	963,830		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	114,937		54.00
57.00	05700	CT SCAN	0	61,659		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	65,136		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	616,883		59.00
60.00	06000	LABORATORY	0	181,826		60.00
65.00	06500	RESPIRATORY THERAPY	0	333,383		65.00
66.00	06600	PHYSICAL THERAPY	0	18,234		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	305,468		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	509,703		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	356,776		73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	319,316		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	7,518,164		118.00
		NONREIMBURSABLE COST CENTERS				
193.00	19300	NONPAID WORKERS	0	0		193.00
193.01	19301	MARKETING	0	73,892		193.01
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118-201)	0	7,592,056		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150153 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B-1 | Date/Time Prepared: 11/24/2014 5:24 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	112,546					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		112,546				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	394	394	27,792,534			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,902	7,902	4,097,170	-16,955,626	80,347,571	5.00
7.00	00700	OPERATION OF PLANT	19,922	19,922	485,572	0	5,549,497	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,498	1,498	31,241	0	512,685	8.00
9.00	00900	HOUSEKEEPING	3,182	3,182	0	0	994,016	9.00
10.00	01000	DIETARY	2,431	2,431	0	0	519,562	10.00
11.00	01100	CAFETERIA	2,389	2,389	0	0	987,792	11.00
13.00	01300	NURSING ADMINISTRATION	2,508	2,508	957,625	0	1,476,193	13.00
15.00	01500	PHARMACY	2,556	2,556	1,591,923	0	2,156,012	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,609	2,609	1,681,159	0	2,738,092	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	39,221	39,221	10,561,585	0	16,027,285	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,028	11,028	3,366,006	0	4,197,565	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	992	992	456,915	0	955,478	54.00
57.00	05700	CT SCAN	593	593	257,612	0	494,085	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	624	624	229,870	0	347,181	58.00
59.00	05900	CARDIAC CATHETERIZATION	6,270	6,270	1,474,406	0	2,393,271	59.00
60.00	06000	LABORATORY	1,424	1,424	0	0	2,484,992	60.00
65.00	06500	RESPIRATORY THERAPY	3,641	3,641	1,109,763	0	1,660,429	65.00
66.00	06600	PHYSICAL THERAPY	0	0	319,984	0	416,006	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	10,884,960	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	18,143,931	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	2,909,120	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,362	3,362	1,171,703	0	1,693,584	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	112,546	112,546	27,792,534	-16,955,626	77,541,736	118.00
		NONREIMBURSABLE COST CENTERS						
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MARKETING	0	0	0	0	2,805,835	193.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,560,994	3,331,910	7,833,512		16,955,626	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	22.755087	29.604873	0.281857		0.211028	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			20,630		2,115,941	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000742		0.026335	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150153 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B-1 | Date/Time Prepared: 11/24/2014 5:24 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	84,328					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,498	568,767				8.00
9.00	00900	HOUSEKEEPING	3,182	0	79,648			9.00
10.00	01000	DIETARY	2,431	0	2,431	45,840		10.00
11.00	01100	CAFETERIA	2,389	0	2,389	0	687,788	11.00
13.00	01300	NURSING ADMINISTRATION	2,508	0	2,508	0	22,946	13.00
15.00	01500	PHARMACY	2,556	0	2,556	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,609	0	2,609	0	48,282	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	39,221	355,480	39,221	45,334	356,140	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,028	54,689	11,028	0	73,821	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	992	0	992	0	13,601	54.00
57.00	05700	CT SCAN	593	0	593	0	7,491	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	624	38,282	624	0	6,232	58.00
59.00	05900	CARDIAC CATHETERIZATION	6,270	38,282	6,270	0	39,361	59.00
60.00	06000	LABORATORY	1,424	0	1,424	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	3,641	27,345	3,641	32	36,393	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	9,336	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	37,371	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,362	54,689	3,362	474	36,814	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	84,328	568,767	79,648	45,840	687,788	118.00
		NONREIMBURSABLE COST CENTERS						
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MARKETING	0	0	0	0	0	193.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	6,720,596	740,260	1,457,373	867,427	1,430,351	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	79.695902	1.301517	18.297672	18.922928	2.079639	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,189,621	113,092	237,676	182,518	191,933	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	14.107070	0.198837	2.984080	3.981632	0.279058	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150153 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B-1 | Date/Time Prepared: 11/24/2014 5:24 pm

		Cost Center Description	NURSING ADMINISTRATION (HOURS)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			13.00	15.00	16.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION	664,842				13.00
15.00	01500	PHARMACY	0	1,000			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	48,282	0	407,530,666		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	356,140	0	69,768,940		30.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	73,821	0	41,550,649		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,601	0	17,563,057		54.00
57.00	05700	CT SCAN	7,491	0	3,873,245		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	6,232	0	1,534,504		58.00
59.00	05900	CARDIAC CATHETERIZATION	39,361	0	122,965,355		59.00
60.00	06000	LABORATORY	0	0	25,089,466		60.00
65.00	06500	RESPIRATORY THERAPY	36,393	0	11,750,712		65.00
66.00	06600	PHYSICAL THERAPY	9,336	0	1,928,593		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	26,991,792		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	45,766,832		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	37,371	1,000	31,394,405		73.00
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	36,814	0	7,353,116		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	664,842	1,000	407,530,666		118.00
		NONREIMBURSABLE COST CENTERS					
193.00	19300	NONPAID WORKERS	0	0	0		193.00
193.01	19301	MARKETING	0	0	0		193.01
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,081,198	2,861,463	3,823,121		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	3.130365	2,861.463000	0.009381		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	220,174	235,477	284,014		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.331167	235.477000	0.000697		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150153 | Period: From 07/01/2013 To 06/30/2014 | Worksheet C Part I Date/Time Prepared: 11/24/2014 5:24 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	27,083,403		27,083,403	0	27,083,403	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,009,616		7,009,616	0	7,009,616	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,489,940		1,489,940	0	1,489,940	54.00
57.00	05700	CT SCAN	731,826		731,826	0	731,826	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	578,282		578,282	0	578,282	58.00
59.00	05900	CARDIAC CATHETERIZATION	4,921,247		4,921,247	0	4,921,247	59.00
60.00	06000	LABORATORY	3,384,302		3,384,302	0	3,384,302	60.00
65.00	06500	RESPIRATORY THERAPY	2,703,657	0	2,703,657	0	2,703,657	65.00
66.00	06600	PHYSICAL THERAPY	570,528	0	570,528	0	570,528	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	13,435,201		13,435,201	0	13,435,201	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	22,402,185		22,402,185	0	22,402,185	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,873,703		6,873,703	0	6,873,703	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	2,721,362		2,721,362	0	2,721,362	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,147,507		2,147,507		2,147,507	92.00
200.00		Subtotal (see instructions)	96,052,759	0	96,052,759	0	96,052,759	200.00
201.00		Less Observation Beds	2,147,507		2,147,507		2,147,507	201.00
202.00		Total (see instructions)	93,905,252	0	93,905,252	0	93,905,252	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150153 | Period: From 07/01/2013 To 06/30/2014 | Worksheet C Part I Date/Time Prepared: 11/24/2014 5:24 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	66,591,028		66,591,028			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	33,792,201	7,758,448	41,550,649	0.168701	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,823,908	4,739,149	17,563,057	0.084834	0.000000	54.00
57.00	05700	CT SCAN	944,066	2,929,179	3,873,245	0.188944	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	421,426	1,113,078	1,534,504	0.376853	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	73,281,968	49,683,387	122,965,355	0.040021	0.000000	59.00
60.00	06000	LABORATORY	20,642,917	4,446,549	25,089,466	0.134889	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	7,789,619	3,961,093	11,750,712	0.230085	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,836,347	92,246	1,928,593	0.295826	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	22,715,768	4,276,024	26,991,792	0.497751	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	32,078,376	13,688,456	45,766,832	0.489485	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	28,143,690	3,250,715	31,394,405	0.218947	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	2,306,666	5,046,450	7,353,116	0.370096	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	3,177,912	3,177,912	0.675760	0.000000	92.00
200.00		Subtotal (see instructions)	303,367,980	104,162,686	407,530,666			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	303,367,980	104,162,686	407,530,666			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 150153	Period: From 07/01/2013 To 06/30/2014	Worksheet C Part I Date/Time Prepared: 11/24/2014 5:24 pm
	Title XVIII	Hospital	PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.168701	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.084834	54.00
57.00	05700	CT SCAN	0.188944	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.376853	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.040021	59.00
60.00	06000	LABORATORY	0.134889	60.00
65.00	06500	RESPIRATORY THERAPY	0.230085	65.00
66.00	06600	PHYSICAL THERAPY	0.295826	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.497751	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.489485	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.218947	73.00
		OUTPATIENT SERVICE COST CENTERS		
91.00	09100	EMERGENCY	0.370096	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.675760	92.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150153 | Period: From 07/01/2013 To 06/30/2014 | Worksheet C Part I Date/Time Prepared: 11/24/2014 5:24 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	27,083,403		27,083,403	0	27,083,403	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,009,616		7,009,616	0	7,009,616	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,489,940		1,489,940	0	1,489,940	54.00
57.00	05700	CT SCAN	731,826		731,826	0	731,826	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	578,282		578,282	0	578,282	58.00
59.00	05900	CARDIAC CATHETERIZATION	4,921,247		4,921,247	0	4,921,247	59.00
60.00	06000	LABORATORY	3,384,302		3,384,302	0	3,384,302	60.00
65.00	06500	RESPIRATORY THERAPY	2,703,657	0	2,703,657	0	2,703,657	65.00
66.00	06600	PHYSICAL THERAPY	570,528	0	570,528	0	570,528	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	13,435,201		13,435,201	0	13,435,201	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	22,402,185		22,402,185	0	22,402,185	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,873,703		6,873,703	0	6,873,703	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	2,721,362		2,721,362	0	2,721,362	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,147,507		2,147,507		2,147,507	92.00
200.00		Subtotal (see instructions)	96,052,759	0	96,052,759	0	96,052,759	200.00
201.00		Less Observation Beds	2,147,507		2,147,507		2,147,507	201.00
202.00		Total (see instructions)	93,905,252	0	93,905,252	0	93,905,252	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150153 | Period: From 07/01/2013 To 06/30/2014 | Worksheet C Part I Date/Time Prepared: 11/24/2014 5:24 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	66,591,028		66,591,028			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	33,792,201	7,758,448	41,550,649	0.168701	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,823,908	4,739,149	17,563,057	0.084834	0.000000	54.00
57.00	05700	CT SCAN	944,066	2,929,179	3,873,245	0.188944	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	421,426	1,113,078	1,534,504	0.376853	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	73,281,968	49,683,387	122,965,355	0.040021	0.000000	59.00
60.00	06000	LABORATORY	20,642,917	4,446,549	25,089,466	0.134889	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	7,789,619	3,961,093	11,750,712	0.230085	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,836,347	92,246	1,928,593	0.295826	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	22,715,768	4,276,024	26,991,792	0.497751	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	32,078,376	13,688,456	45,766,832	0.489485	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	28,143,690	3,250,715	31,394,405	0.218947	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	2,306,666	5,046,450	7,353,116	0.370096	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	3,177,912	3,177,912	0.675760	0.000000	92.00
200.00		Subtotal (see instructions)	303,367,980	104,162,686	407,530,666			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	303,367,980	104,162,686	407,530,666			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150153 | Period: From 07/01/2013 To 06/30/2014 | Worksheet C Part I Date/Time Prepared: 11/24/2014 5:24 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

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

Provider CCN: 150153 | Period: From 07/01/2013 To 06/30/2014 | Worksheet C Part II Date/Time Prepared: 11/24/2014 5:24 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,009,616	963,830	6,045,786	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,489,940	114,937	1,375,003	0	0	54.00
57.00	05700	CT SCAN	731,826	61,659	670,167	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	578,282	65,136	513,146	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	4,921,247	616,883	4,304,364	0	0	59.00
60.00	06000	LABORATORY	3,384,302	181,826	3,202,476	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	2,703,657	333,383	2,370,274	0	0	65.00
66.00	06600	PHYSICAL THERAPY	570,528	18,234	552,294	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	13,435,201	305,468	13,129,733	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	22,402,185	509,703	21,892,482	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,873,703	356,776	6,516,927	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	2,721,362	319,316	2,402,046	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,147,507	291,084	1,856,423	0	0	92.00
200.00		Subtotal (sum of lines 50 thru 199)	68,969,356	4,138,235	64,831,121	0	0	200.00
201.00		Less Observation Beds	2,147,507	291,084	1,856,423	0	0	201.00
202.00		Total (line 200 minus line 201)	66,821,849	3,847,151	62,974,698	0	0	202.00

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

Provider CCN: 150153 | Period: From 07/01/2013 To 06/30/2014 | Worksheet C Part II Date/Time Prepared: 11/24/2014 5:24 pm

Title XIX | Hospital | Cost

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	7,009,616	41,550,649	0.168701		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,489,940	17,563,057	0.084834		54.00
57.00	05700	CT SCAN	731,826	3,873,245	0.188944		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	578,282	1,534,504	0.376853		58.00
59.00	05900	CARDIAC CATHETERIZATION	4,921,247	122,965,355	0.040021		59.00
60.00	06000	LABORATORY	3,384,302	25,089,466	0.134889		60.00
65.00	06500	RESPIRATORY THERAPY	2,703,657	11,750,712	0.230085		65.00
66.00	06600	PHYSICAL THERAPY	570,528	1,928,593	0.295826		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	13,435,201	26,991,792	0.497751		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	22,402,185	45,766,832	0.489485		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,873,703	31,394,405	0.218947		73.00
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	2,721,362	7,353,116	0.370096		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,147,507	3,177,912	0.675760		92.00
200.00		Subtotal (sum of lines 50 thru 199)	68,969,356	340,939,638			200.00
201.00		Less Observation Beds	2,147,507	0			201.00
202.00		Total (line 200 minus line 201)	66,821,849	340,939,638			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 150153 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part I | Date/Time Prepared: 11/24/2014 5:24 pm

Title XVIII | Hospital | PPS

	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	3,671,013	0	3,671,013	19,838	185.05	30.00
200.00	Total (lines 30-199)	3,671,013		3,671,013	19,838		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	10,313	1,908,421		30.00
200.00	Total (lines 30-199)	10,313	1,908,421		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 150153 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part II Date/Time Prepared: 11/24/2014 5:24 pm

Title XVIII | Hospital | 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	963,830	41,550,649	0.023197	22,325,685	517,889	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	114,937	17,563,057	0.006544	5,472,385	35,811	54.00
57.00	05700	CT SCAN	61,659	3,873,245	0.015919	592,521	9,432	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	65,136	1,534,504	0.042448	165,135	7,010	58.00
59.00	05900	CARDIAC CATHETERIZATION	616,883	122,965,355	0.005017	33,321,909	167,176	59.00
60.00	06000	LABORATORY	181,826	25,089,466	0.007247	14,187,228	102,815	60.00
65.00	06500	RESPIRATORY THERAPY	333,383	11,750,712	0.028371	4,260,829	120,884	65.00
66.00	06600	PHYSICAL THERAPY	18,234	1,928,593	0.009455	1,204,168	11,385	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	305,468	26,991,792	0.011317	11,812,502	133,682	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	509,703	45,766,832	0.011137	22,302,407	248,382	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	356,776	31,394,405	0.011364	14,907,252	169,406	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	319,316	7,353,116	0.043426	1,327,764	57,659	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	291,084	3,177,912	0.091596	0	0	92.00
200.00		Total (lines 50-199)	4,138,235	340,939,638		131,879,785	1,581,531	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 150153 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part III Date/Time Prepared: 11/24/2014 5:24 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	19,838	0.00	10,313	0		30.00
200.00		Total (lines 30-199)	19,838		10,313	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150153 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part IV | Date/Time Prepared: 11/24/2014 5:24 pm

Title XVIII | Hospital | PPS

		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	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 150153 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part IV Date/Time Prepared: 11/24/2014 5:24 pm

Title XVIII | Hospital | PPS

		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	41,550,649	0.000000	0.000000	22,325,685	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	17,563,057	0.000000	0.000000	5,472,385	54.00
57.00	05700	CT SCAN	0	3,873,245	0.000000	0.000000	592,521	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,534,504	0.000000	0.000000	165,135	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	122,965,355	0.000000	0.000000	33,321,909	59.00
60.00	06000	LABORATORY	0	25,089,466	0.000000	0.000000	14,187,228	60.00
65.00	06500	RESPIRATORY THERAPY	0	11,750,712	0.000000	0.000000	4,260,829	65.00
66.00	06600	PHYSICAL THERAPY	0	1,928,593	0.000000	0.000000	1,204,168	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	26,991,792	0.000000	0.000000	11,812,502	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	45,766,832	0.000000	0.000000	22,302,407	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	31,394,405	0.000000	0.000000	14,907,252	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	7,353,116	0.000000	0.000000	1,327,764	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	3,177,912	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	340,939,638			131,879,785	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150153 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part IV | Date/Time Prepared: 11/24/2014 5:24 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	7,526,706	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,175,162	0		54.00
57.00	05700	CT SCAN	0	1,549,839	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	225,165	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	20,891,337	0		59.00
60.00	06000	LABORATORY	0	1,056,317	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	67,436	0		65.00
66.00	06600	PHYSICAL THERAPY	0	43,067	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,342,294	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	8,437,764	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,544,412	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0	1,989,647	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,485,691	0		92.00
200.00		Total (lines 50-199)	0	49,334,837	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 150153 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part V Date/Time Prepared: 11/24/2014 5:24 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.168701	7,526,706	0	0	1,269,763	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.084834	2,175,162	0	0	184,528	54.00
57.00	05700	CT SCAN	0.188944	1,549,839	0	0	292,833	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.376853	225,165	0	0	84,854	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.040021	20,891,337	0	0	836,092	59.00
60.00	06000	LABORATORY	0.134889	1,056,317	0	0	142,486	60.00
65.00	06500	RESPIRATORY THERAPY	0.230085	67,436	0	0	15,516	65.00
66.00	06600	PHYSICAL THERAPY	0.295826	43,067	0	0	12,740	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.497751	2,342,294	0	0	1,165,879	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.489485	8,437,764	0	0	4,130,159	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.218947	1,544,412	0	13,858	338,144	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.370096	1,989,647	0	0	736,360	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.675760	1,485,691	0	0	1,003,971	92.00
200.00		Subtotal (see instructions)		49,334,837	0	13,858	10,213,325	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		49,334,837	0	13,858	10,213,325	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 150153 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part V Date/Time Prepared: 11/24/2014 5:24 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,034		73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	3,034		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	3,034		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 150153 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part I Date/Time Prepared: 11/24/2014 5:24 pm

Title XIX | Hospital | Cost

	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	3,671,013	0	3,671,013	19,838	185.05	30.00
200.00	Total (lines 30-199)	3,671,013		3,671,013	19,838		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	409	75,685	30.00
200.00	Total (lines 30-199)	409	75,685	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 150153 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part II Date/Time Prepared: 11/24/2014 5:24 pm

Title XIX | Hospital | Cost

		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	963,830	41,550,649	0.023197	1,090,979	25,307	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	114,937	17,563,057	0.006544	236,282	1,546	54.00
57.00	05700	CT SCAN	61,659	3,873,245	0.015919	22,640	360	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	65,136	1,534,504	0.042448	19,189	815	58.00
59.00	05900	CARDIAC CATHETERIZATION	616,883	122,965,355	0.005017	2,303,511	11,557	59.00
60.00	06000	LABORATORY	181,826	25,089,466	0.007247	432,159	3,132	60.00
65.00	06500	RESPIRATORY THERAPY	333,383	11,750,712	0.028371	229,071	6,499	65.00
66.00	06600	PHYSICAL THERAPY	18,234	1,928,593	0.009455	31,315	296	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	305,468	26,991,792	0.011317	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	509,703	45,766,832	0.011137	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	356,776	31,394,405	0.011364	674,353	7,663	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	319,316	7,353,116	0.043426	15,636	679	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	291,084	3,177,912	0.091596	0	0	92.00
200.00		Total (lines 50-199)	4,138,235	340,939,638		5,055,135	57,854	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 150153 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part III Date/Time Prepared: 11/24/2014 5:24 pm

Title XIX | Hospital | Cost

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	19,838	0.00	409	0		30.00
200.00		Total (lines 30-199)	19,838		409	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150153 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part IV | Date/Time Prepared: 11/24/2014 5:24 pm

Title XIX | Hospital | Cost

		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	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 150153 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part IV Date/Time Prepared: 11/24/2014 5:24 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	41,550,649	0.000000	0.000000	1,090,979	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	17,563,057	0.000000	0.000000	236,282	54.00
57.00	05700	CT SCAN	0	3,873,245	0.000000	0.000000	22,640	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,534,504	0.000000	0.000000	19,189	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	122,965,355	0.000000	0.000000	2,303,511	59.00
60.00	06000	LABORATORY	0	25,089,466	0.000000	0.000000	432,159	60.00
65.00	06500	RESPIRATORY THERAPY	0	11,750,712	0.000000	0.000000	229,071	65.00
66.00	06600	PHYSICAL THERAPY	0	1,928,593	0.000000	0.000000	31,315	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	26,991,792	0.000000	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	45,766,832	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	31,394,405	0.000000	0.000000	674,353	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	7,353,116	0.000000	0.000000	15,636	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	3,177,912	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	340,939,638			5,055,135	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150153 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part IV | Date/Time Prepared: 11/24/2014 5:24 pm

Title XIX | Hospital | Cost

		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	231,742	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	129,144	0		54.00
57.00	05700	CT SCAN	0	37,760	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	25,696	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,827,660	0		59.00
60.00	06000	LABORATORY	0	112,387	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	42,954	0		65.00
66.00	06600	PHYSICAL THERAPY	0	2,237	0		66.00
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	126,349	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0	66,907	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00		Total (lines 50-199)	0	2,602,836	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 150153 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part V Date/Time Prepared: 11/24/2014 5:24 pm

Title XIX | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.168701	231,742	0	0	39,095	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.084834	129,144	0	0	10,956	54.00
57.00	05700	CT SCAN	0.188944	37,760	0	0	7,135	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.376853	25,696	0	0	9,684	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.040021	1,827,660	0	0	73,145	59.00
60.00	06000	LABORATORY	0.134889	112,387	0	0	15,160	60.00
65.00	06500	RESPIRATORY THERAPY	0.230085	42,954	0	0	9,883	65.00
66.00	06600	PHYSICAL THERAPY	0.295826	2,237	0	0	662	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.497751	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.489485	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.218947	126,349	0	0	27,664	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.370096	66,907	0	0	24,762	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.675760	0	0	0	0	92.00
200.00		Subtotal (see instructions)		2,602,836	0	0	218,146	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		2,602,836	0	0	218,146	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 150153 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part V Date/Time Prepared: 11/24/2014 5:24 pm

Title XIX | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	0	0	202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150153 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D-1 | Date/Time Prepared: 11/24/2014 5:24 pm

Title XVIII | Hospital | 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)	19,838	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	19,838	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	18,265	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)	10,313	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	27,083,403	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)	27,083,403	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	27,083,403	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,365.23	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	14,079,617	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)	14,079,617	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150153 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D-1 | Date/Time Prepared: 11/24/2014 5:24 pm

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	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	29,540,325	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	43,619,942	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)	1,908,421	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	1,581,531	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	3,489,952	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	40,129,990	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)	1,573	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,365.23	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,147,507	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150153 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D-1 | Date/Time Prepared: 11/24/2014 5:24 pm

Title XVIII | Hospital | 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	3,671,013	27,083,403	0.135545	2,147,507	291,084	90.00
91.00	Nursing School cost	0	27,083,403	0.000000	2,147,507	0	91.00
92.00	Allied health cost	0	27,083,403	0.000000	2,147,507	0	92.00
93.00	All other Medical Education	0	27,083,403	0.000000	2,147,507	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150153 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D-1 | Date/Time Prepared: 11/24/2014 5:24 pm

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	19,838	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	19,838	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	18,265	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)	409	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	27,083,403	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)	27,083,403	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	27,083,403	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,365.23	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	558,379	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)	558,379	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150153 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D-1 | Date/Time Prepared: 11/24/2014 5:24 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)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	581,490	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,139,869	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)	1,573	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,365.23	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,147,507	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150153 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D-1 | Date/Time Prepared: 11/24/2014 5:24 pm

Title XIX | Hospital | Cost

	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	3,671,013	27,083,403	0.135545	2,147,507	291,084	90.00
91.00	Nursing School cost	0	27,083,403	0.000000	2,147,507	0	91.00
92.00	Allied health cost	0	27,083,403	0.000000	2,147,507	0	92.00
93.00	All other Medical Education	0	27,083,403	0.000000	2,147,507	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 150153 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D-3 | Date/Time Prepared: 11/24/2014 5:24 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		33,808,526		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.168701	22,325,685	3,766,365	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.084834	5,472,385	464,244	54.00
57.00	05700	CT SCAN	0.188944	592,521	111,953	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.376853	165,135	62,232	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.040021	33,321,909	1,333,576	59.00
60.00	06000	LABORATORY	0.134889	14,187,228	1,913,701	60.00
65.00	06500	RESPIRATORY THERAPY	0.230085	4,260,829	980,353	65.00
66.00	06600	PHYSICAL THERAPY	0.295826	1,204,168	356,224	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.497751	11,812,502	5,879,685	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.489485	22,302,407	10,916,694	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.218947	14,907,252	3,263,898	73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.370096	1,327,764	491,400	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.675760	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		131,879,785	29,540,325	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)		131,879,785		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 150153 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D-3 | Date/Time Prepared: 11/24/2014 5:24 pm

Title XIX | Hospital | 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		1,519,877		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.168701	1,090,979	184,049	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.084834	236,282	20,045	54.00
57.00	05700	CT SCAN	0.188944	22,640	4,278	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.376853	19,189	7,231	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.040021	2,303,511	92,189	59.00
60.00	06000	LABORATORY	0.134889	432,159	58,293	60.00
65.00	06500	RESPIRATORY THERAPY	0.230085	229,071	52,706	65.00
66.00	06600	PHYSICAL THERAPY	0.295826	31,315	9,264	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.497751	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.489485	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.218947	674,353	147,648	73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.370096	15,636	5,787	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.675760	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		5,055,135	581,490	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)		5,055,135		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 150153 | Period: From 07/01/2013 To 06/30/2014 | Worksheet E Part A Date/Time Prepared: 11/24/2014 5:24 pm

Title XVIII | Hospital | PPS

			before 1/1	on/after 1/1		
		0	1.00	1.01	2.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER PPS					
1.00	DRG Amounts Other than Outlier Payments		0			1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1, 2013 (see instructions)		0			1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1, 2013 (see instructions)		31,582,252			1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI (see instructions)		0			1.03
2.00	Outlier payments for discharges. (see instructions)		927,591			2.00
2.01	Outlier reconciliation amount		0			2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0			2.02
3.00	Managed Care Simulated Payments		0			3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		102.69			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	Adjusment 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 factor. (see instructions)		0.000000			27.00
28.00	IME add-on adjustment amount (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)		1.40			30.00
31.00	Percentage of Medicaid patient days (see instructions)		3.03			31.00
32.00	Sum of lines 30 and 31		4.43			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 150153 | Period: From 07/01/2013 To 06/30/2014 | Worksheet E Part A | Date/Time Prepared: 11/24/2014 5:24 pm

Title XVIII | Hospital | PPS

			before 1/1	on/after 1/1		
		0	1.00	1.01	2.00	
33.00	Allowable disproportionate share percentage (see instructions)		0.00			33.00
34.00	Disproportionate share adjustment (see instructions)		0			34.00

			Prior to October 1		On/After October 1	
		0	1.00	1.01	2.00	
	Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)				0	35.00
35.01	Factor 3 (see instructions)				0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)				0	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)				0	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		0			36.00
	Additional payment for high percentage of ESRD beneficiary discharges					
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0			40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0	0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00			42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0			43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000			44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0			46.00
47.00	Subtotal (see instructions)		32,509,843			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)		32,509,843			49.00
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)		2,621,760			50.00
51.00	Exception payment for inpatient program capital (Worksheet L, Part III, see instructions)		0			51.00
52.00	Direct graduate medical education payment (from Worksheet E-4, line 49 see instructions).		0			52.00
53.00	Nursing and Allied Health Managed Care payment		0			53.00
54.00	Special add-on payments for new technologies		0			54.00
55.00	Net organ acquisition cost (Worksheet D-4 Part III, col. 1, line 69)		0			55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)		0			56.00
57.00	Routine service other pass through costs (from Wkst D, Part III, column 9, lines 30 through 35).		0			57.00
58.00	Ancillary service other pass through costs from Worksheet D, Part IV, col. 11 line 200)		0			58.00
59.00	Total (sum of amounts on lines 49 through 58)		35,131,603			59.00
60.00	Primary payer payments		15,651			60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		35,115,952			61.00
62.00	Deductibles billed to program beneficiaries		2,132,736			62.00
63.00	Coinsurance billed to program beneficiaries		20,664			63.00
64.00	Allowable bad debts (see instructions)		74,887			64.00
65.00	Adjusted reimbursable bad debts (see instructions)		48,677			65.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150153	Period: From 07/01/2013 To 06/30/2014	Worksheet E Part A Date/Time Prepared: 11/24/2014 5:24 pm
	Title XVIII	Hospital	PPS

			Prior to October 1		On/After October 1	
		0	1.00	1.01	2.00	
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		5,785			66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		33,011,229			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
70.50	RURAL DEMONSTRATION PROJECT		0			70.50
70.92	Bundled Model 1 discount amount		0			70.92
70.93	HVBP incentive payment (see instructions)		134,314			70.93
70.94	Hospital readmissions reduction adjustment (see instructions)		-898			70.94
70.95	Recovery of accelerated depreciation		0			70.95
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0			70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (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)		33,144,645			71.00
71.01	Sequestration adjustment (see instructions)		662,893			71.01
72.00	Interim payments		32,471,577			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		10,175			74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0			75.00
	TO BE COMPLETED BY CONTRACTOR					
90.00	Operating outlier amount from Worksheet E, Part A line 2 (see instructions)		0			90.00
91.00	Capital outlier from Worksheet L, Part I, line 2		0			91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0			92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0			93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00			94.00
95.00	Time value of money for operating expenses (see instructions)		0			95.00
96.00	Time value of money for capital related expenses (see instructions)		0			96.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 150153 | Period: From 07/01/2013 To 06/30/2014 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 11/24/2014 5:24 pm

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1, 2013	1.01	0	0	0	0	0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1, 2013	1.02	31,582,252	0	0	31,582,252	31,582,252	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI	1.03	0	0	0	0	0	1.03
2.00	Outlier payments for discharges (see instructions)	2.00	927,591	0	0	927,591	927,591	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	Amount from Worksheet E Part A, line 27 (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0000	0.0000	0.0000	0.0000		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	0	0	0	0	0	11.00
11.01	Uncompensated care payments	36.00	0	0	0	0	0	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	32,509,843	0	0	32,509,843	32,509,843	13.00
14.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)	49.00	32,509,843	0	0	32,509,843	32,509,843	15.00
16.00	Payment for inpatient program capital (from Worksheet L, Parts I, as applicable)	50.00	2,621,760	0	0	2,621,760	2,621,760	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	0	35,131,603	35,131,603	19.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 150153 | Period: From 07/01/2013 To 06/30/2014 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 11/24/2014 5:24 pm

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		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	2,519,753	0	0	2,519,753	2,519,753	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	79,329	0	0	79,329	79,329	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (line 20 times line 22)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0090	0.0090	0.0090	0.0090		24.00
25.00	Disproportionate share adjustment (line 20 times line 24)	11.00	22,678	0	0	22,678	22,678	25.00
26.00	Total prospective capital payments (sum of lines 20-21, 23 and 25)	12.00	2,621,760	0	0	2,621,760	2,621,760	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to W/S E Part A line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to W/S E Part A line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to W/S E Part A.		Y					100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150153	Period: From 07/01/2013 To 06/30/2014	Worksheet E Part B Date/Time Prepared: 11/24/2014 5:24 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	3,034	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	10,213,325	2.00
3.00	PPS payments	11,056,865	3.00
4.00	Outlier payment (see instructions)	195,207	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	3,034	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	13,858	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)	13,858	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 chargebasis 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)	13,858	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	10,824	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)	3,034	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	11,252,072	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,736,628	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)	9,518,478	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)	9,518,478	30.00
31.00	Primary payer payments	221	31.00
32.00	Subtotal (line 30 minus line 31)	9,518,257	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)	138,274	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	89,878	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	106,744	36.00
37.00	Subtotal (see instructions)	9,608,135	37.00
38.00	MSP-LCC reconciliation amount from PS&R	614	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	9,607,521	40.00
40.01	Sequestration adjustment (see instructions)	192,150	40.01
41.00	Interim payments	9,404,526	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	10,845	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §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: 150153 | Period: From 07/01/2013 To 06/30/2014 | Worksheet E-1 Part I | Date/Time Prepared: 11/24/2014 5:24 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		32,438,577		9,404,526	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	01/31/2014	33,000		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)		33,000		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)		32,471,577		9,404,526	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		10,175		10,845	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		32,481,752		9,415,371	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150153	Period: From 07/01/2013 To 06/30/2014	Worksheet E-3 Part VII Date/Time Prepared: 11/24/2014 5:24 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	1,139,869		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	1,139,869	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	1,139,869	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	1,641,863		8.00
9.00	Ancillary service charges	5,055,135	2,602,836	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)	6,696,998	2,602,836	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)	6,696,998	2,602,836	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	5,557,129	2,602,836	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	1,139,869	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	1,139,869	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	1,139,869	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	1,139,869	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	1,139,869	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	1,139,869	0	40.00
41.00	Interim payments	1,139,869	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 150153 | Period: From 07/01/2013 To 06/30/2014 | Worksheet G | Date/Time Prepared: 11/24/2014 5:24 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	23,144,924	0	0	0	1.00
2.00	Temporary investments	14,114,514	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	39,915,064	0	0	0	4.00
5.00	Other receivable	12,727,404	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-26,054,788	0	0	0	6.00
7.00	Inventory	2,139,480	0	0	0	7.00
8.00	Prepaid expenses	260,054	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	-25,221	25,221	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	66,221,431	25,221	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	43,816,123	0	0	0	15.00
16.00	Accumulated depreciation	-27,074,495	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	6,258,340	0	0	0	19.00
20.00	Accumulated depreciation	-6,197,125	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	18,815,361	0	0	0	23.00
24.00	Accumulated depreciation	-13,363,697	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	22,254,507	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	207,451	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	207,451	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	88,683,389	25,221	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	11,294,327	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,725,519	0	0	0	38.00
39.00	Payroll taxes payable	511,145	0	0	0	39.00
40.00	Notes and loans payable (short term)	3,561,154	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	17,205,157	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	34,297,302	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	28,489,231	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	28,489,231	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	62,786,533	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	25,896,856				52.00
53.00	Specific purpose fund		25,221			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)	25,896,856	25,221	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	88,683,389	25,221	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 150153 | Period: From 07/01/2013 To 06/30/2014 | Worksheet G-1 | Date/Time Prepared: 11/24/2014 5:24 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		33,573,311		15,994		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		26,314,555				2.00
3.00	Total (sum of line 1 and line 2)		59,887,866		15,994		3.00
4.00	GRANT REVENUE	0		20,000		0	4.00
5.00	CONTRIBUTIONS	6,990		0		0	5.00
6.00	OTHER ADDITIONS	0		15,154		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)		6,990		35,154		10.00
11.00	Subtotal (line 3 plus line 10)		59,894,856		51,148		11.00
12.00	TRANSFERS TO AFFILIATES	25,170,046		0		0	12.00
13.00	RELEASED OPERATING	0		18,937		0	13.00
14.00	RELEASED CAPITAL	0		6,990		0	14.00
15.00	DISTRIBUTION	8,812,800		0		0	15.00
16.00	OTHER DEDUCTION	15,154		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		33,998,000		25,927		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		25,896,856		25,221		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	GRANT REVENUE		0			4.00
5.00	CONTRIBUTIONS		0			5.00
6.00	OTHER ADDITIONS		0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	TRANSFERS TO AFFILIATES		0			12.00
13.00	RELEASED OPERATING		0			13.00
14.00	RELEASED CAPITAL		0			14.00
15.00	DISTRIBUTION		0			15.00
16.00	OTHER DEDUCTION		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: 150153 | Period: From 07/01/2013 To 06/30/2014 | Worksheet G-2 Parts I & II | Date/Time Prepared: 11/24/2014 5:24 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	70,065,061		70,065,061	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	70,065,061		70,065,061	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	70,065,061		70,065,061	17.00
18.00	Ancillary services	238,590,718	91,489,500	330,080,218	18.00
19.00	Outpatient services	2,326,492	5,058,897	7,385,389	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	310,982,271	96,548,397	407,530,668	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		105,750,825		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		105,750,825		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 150153	Period: From 07/01/2013 To 06/30/2014	Worksheet G-3 Date/Time Prepared: 11/24/2014 5:24 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	407,530,668	1.00
2.00	Less contractual allowances and discounts on patients' accounts	279,250,407	2.00
3.00	Net patient revenues (line 1 minus line 2)	128,280,261	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	105,750,825	4.00
5.00	Net income from service to patients (line 3 minus line 4)	22,529,436	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	935,763	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	457,484	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	14,312	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS REVENUE	44,165	24.00
24.01	OTHER OPERATING REVENUE	30,587	24.01
24.02	PURCHASE DISCOUNTS	2,302,808	24.02
25.00	Total other income (sum of lines 6-24)	3,785,119	25.00
26.00	Total (line 5 plus line 25)	26,314,555	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	26,314,555	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 150153	Period: From 07/01/2013 To 06/30/2014	Worksheet L Parts I-III Date/Time Prepared: 11/24/2014 5:24 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	2,519,753	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	79,329	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	50.04	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 (multiply line 5 by the sum of lines 1 and 1.01)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	1.40	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	3.03	8.00
9.00	Sum of lines 7 and 8	4.43	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.90	10.00
11.00	Disproportionate share adjustment (line 10 times the sum of lines 1 and 1.01)	22,678	11.00
12.00	Total prospective capital payments (sum of lines 1, 1.01, 2, 2.01, 6 and 11)	2,621,760	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