

**ST. VINCENT MERCY HOSPITAL**

**PROVIDER NO. 15-1308, 15-Z308, AND AIM NO. 100268360**

**HOSPITAL STATEMENTS OF REIMBURSABLE COSTS  
(MEDICARE AND MEDICAID PROGRAMS)**

**JUNE 30, 2013**

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). FORM APPROVED OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 151308	Period: From 07/01/2012 To 06/30/2013	Worksheet S Parts I-III Date/Time Prepared: 11/22/2013 3:17 pm
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**PART I - COST REPORT STATUS**

Provider use only

1.  Electronically filed cost report  
 2.  Manually submitted cost report  
 3.  If this is an amended report enter the number of times the provider resubmitted this cost report  
 4.  Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5.  Cost Report Status  
 (1) As Submitted  
 (2) Settled without Audit  
 (3) Settled with Audit  
 (4) Reopened  
 (5) Amended

6. Date Received:  
 7. Contractor No.  
 8.  Initial Report for this Provider CCN  
 9.  Final Report for this Provider CCN

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

Date: 11/22/2013 Time: 3:17 pm

**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 MERCY HOSPITAL ( 151308 ) for the cost reporting period beginning 07/01/2012 and ending 06/30/2013 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

**Encryption Information**  
 ECR: Date: 11/22/2013 Time: 3:17 pm  
 H8oL1Eu17jazsY01rQYBKETGArt4V0  
 :nNZO0Z.SQG10vmy9792uUHAKIOBrk  
 EuOK0f4qwG0aQ:bm  
 PI: Date: 11/22/2013 Time: 3:17 pm  
 bMIgVX1mmysen6EdgxmzWrk1ytFeS0  
 Lo36C0lnps1FsadiTyG.NR9Y0aPo99  
 GGkp0mekNk0ynhSU

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

\_\_\_\_\_  
 Title

\_\_\_\_\_  
 Date

	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	74,146	481,813	0	0	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
5.00 Swing bed - SNF	0	1,735	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
200.00 Total	0	75,881	481,813	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151308	Period: From 07/01/2012 To 06/30/2013	Worksheet S-2 Part I Date/Time Prepared: 11/22/2013 12:50 pm
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		1.00	2.00	3.00	4.00				1.00	2.00
<b>Hospital and Hospital Health Care Complex Address:</b>										
1.00	Street: 13311 SOUTH A ST.	PO Box:	Zip Code: 46036-		County: MADISON				1.00	2.00
2.00	City: ELWOOD	State: IN								
		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	
<b>Hospital and Hospital-Based Component Identification:</b>										
3.00	Hospital	ST. VINCENT MERCY HOSPITAL	151308	11300	1	07/01/2001	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	SWING BED - SNF	152308	11300		07/01/2001	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00
							From:	To:		
							1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)						07/01/2012	06/30/2013		20.00
21.00	Type of Control (see instructions)						1			21.00
<b>Inpatient PPS Information:</b>										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	N		22.00	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.						2		23.00	
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days			
		1.00	2.00	3.00	4.00	5.00	6.00			
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0		24.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.	0	0	0	0	0	0		25.00	
							Urban/Rural S	Date of Geogr		
							1.00	2.00		
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.						1		26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.						1		27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.						0		35.00	

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		Beginning: 1.00	Ending: 2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0				37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.					38.00
		Y/N 1.00	Y/N 2.00			
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					39.00
		V 1.00	XVIII 2.00	XIX 3.00		
<b>Prospective Payment System (PPS)-Capital</b>						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N		45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N		46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N		47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00
<b>Teaching Hospitals</b>						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N				56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete worksheet E-4. If column 2 is "N", complete worksheet D, Part III & IV and D-2, Part II, if applicable.					57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete worksheet D-5.	N				58.00
59.00	Are costs claimed on line 100 of worksheet A? If yes, complete worksheet D-2, Part I.	N				59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N				60.00
		Y/N 1.00	IME 2.00	Direct GME 3.00	IME 4.00	Direct GME 5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00		
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN and general surgery) added as a result of section 5503. (see instructions)		0.00	0.00		
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00		
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00		
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00		
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00		
		Program Name 1.00	Program Code 2.00	Unweighted IME FTE Count 3.00	Unweighted Direct GME FTE Count 4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.10

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	Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count		
	1.00	2.00	3.00	4.00		
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.		0.00	0.00	61.20	
				1.00		
<b>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</b>						
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	
<b>Teaching Hospitals that Claim Residents in Non-Provider Settings</b>						
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	
<b>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.</b>						
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	64.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
			1.00	2.00	3.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2.00	3.00	
<b>Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010</b>						
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

	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
<b>Inpatient Psychiatric Facility PPS</b>						
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N		70.00
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)				0	71.00
<b>Inpatient Rehabilitation Facility PPS</b>						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N		75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)				0	76.00
						1.00
<b>Long Term Care Hospital PPS</b>						
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.				N	80.00
<b>TEFRA Providers</b>						
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.				N	85.00
86.00	Did this facility establish a new other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.					86.00
						V XIX
						1.00 2.00
<b>Title V and XIX Services</b>						
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.				Y	92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.			0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.			N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.			0.00	0.00	97.00
<b>Rural Providers</b>						
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?			Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			N		106.00

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		V	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)	N	N			107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N				108.00	
		Physical	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.	N	N	Y	N	109.00	
						1.00	2.00
							3.00
<b>Miscellaneous Cost Reporting Information</b>							
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.			N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.			N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.			Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.			2			118.00
		Premiums	Losses	Insurance			
		1.00	2.00	3.00			
118.01	List amounts of malpractice premiums and paid losses:	86,124	0				118.01
				1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.			N			118.02
119.00	DO NOT USE THIS LINE						119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.			N	N		120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.			Y			121.00
<b>Transplant Center Information</b>							
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.			N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.						134.00
<b>All Providers</b>							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)			Y	15H046		140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151308		Period: From 07/01/2012 To 06/30/2013		Worksheet S-2 Part I Date/Time Prepared: 11/22/2013 12:50 pm							
1.00		2.00		3.00									
<b>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.</b>													
141.00	Name: ST. VINCENT HEALTH	Contractor's Name: WPS		Contractor's Number: 08101				141.00					
142.00	Street: 10330 N. MERIDIAN STREET	PO Box:						142.00					
143.00	City: INDIANAPOLIS	State: IN		Zip Code: 46290				143.00					
144.00 Are provider based physicians' costs included in worksheet A? Y 144.00													
145.00 If costs for renal services are claimed on worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no. N 145.00													
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					
<b>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)</b>													
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	N		N		N		N		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		N		161.00			
165.00 <b>Multicampus</b> 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
167.00 <b>Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act</b> Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no. N 167.00													
168.00 If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions) 0.00 168.00													
169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions) 0.00 169.00													
								Beginning		Ending			
								1.00		2.00			
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)											170.00	

		Y/N	Date	
		1.00	2.00	
<b>General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.</b>				
<b>COMPLETED BY ALL HOSPITALS</b>				
<b>Provider Organization and Operation</b>				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N	Date	V/I
		1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N		3.00
		Y/N	Type	Date
		1.00	2.00	3.00
<b>Financial Data and Reports</b>				
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	
<b>Approved Educational Activities</b>				
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		
<b>Bad Debts</b>				
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
<b>Bed Complement</b>				
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
16.00	PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	10/02/2013	Y
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 151308	Period: From 07/01/2012 To 06/30/2013	Worksheet S-2 Part II Date/Time Prepared: 11/22/2013 12:50 pm
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	Description	Part A		Part B	
		Y/N	Date	Y/N	
	0	1.00	2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>					
<b>Capital Related Cost</b>					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N		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		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		N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N		N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N		N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N		N	27.00
<b>Interest Expense</b>					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N		N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	Y		Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N		N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N		N	31.00
<b>Purchased Services</b>					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N		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		N	33.00
<b>Provider-Based Physicians</b>					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y		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.	Y		Y	35.00
		Y/N	Date		
		1.00	2.00		
<b>Home Office Costs</b>					
36.00	Were home office costs claimed on the cost report?	Y		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		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		N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		N	40.00
		1.00	2.00		
<b>Cost Report Preparer Contact Information</b>					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	JILL	HILL		41.00
42.00	Enter the employer/company name of the cost report preparer.	ST. VINCENT HEALTH			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-583-3519	JILL.HILL@STVINCENT.ORG		43.00

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

Provider CCN: 151308

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

Worksheet S-2  
Part V  
Date/Time Prepared:  
11/22/2013 12:50 pm

		1.00
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**Cost Report Preparer Contact Information**

1.00	First Name		1.00
2.00	Last Name		2.00
3.00	Title		3.00
4.00	Employer	BRADLEY ASSOCIATES	4.00
5.00	Phone Number	(317)237-5500	5.00
6.00	E-mail Address		6.00
7.00	Department		7.00
8.00	Mailing Address 1	201 S. CAPITOL AVE.	8.00
9.00	Mailing Address 2	SUITE 700	9.00
10.00	City	INDIANAPOLIS	10.00
11.00	State	IN	11.00
12.00	Zip	46225	12.00

**Officer or Administrator of Provider Contact Information**

13.00	First Name	JILL	13.00
14.00	Last Name	HILL	14.00
15.00	Title	REIMBURSEMENT MANAGER	15.00
16.00	Employer	ST. VINCENT HEALTH	16.00
17.00	Phone Number	(317)583-2311	17.00
18.00	E-mail Address	JILL.HILL@STVINCENT.ORG	18.00
19.00	Department		19.00
20.00	Mailing Address 1	10330 N. MERIDIAN ST	20.00
21.00	Mailing Address 2	SUITE 420	21.00
22.00	City	INDIANAPOLIS	22.00
23.00	State	IN	23.00
24.00	Zip	46290	24.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151308

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
11/22/2013 12:50 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	Title V
	Line Number				Visits / Trips	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	47,760.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	47,760.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	0	0	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		25	9,125	47,760.00	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)		25				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,148	91	1,990			1.00
2.00 HMO and other (see instructions)	260	40				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	444	0	444			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	62			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	1,592	91	2,496			7.00
8.00 INTENSIVE CARE UNIT	0	0	0			8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	1,592	91	2,496	0.00	146.35	14.00
15.00 CAH visits	12,493	1,782	34,974			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	146.35	27.00
28.00 Observation Bed Days		0	488			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			9			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
33.00 LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151308

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
11/22/2013 12:50 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
		Title V	Title XVIII	Title XIX		
		11.00	12.00	13.00		
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	325	33	596	1.00
2.00 HMO and other (see instructions)			76			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	325	33	596	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

		1.00	
<b>Uncompensated and indigent care cost computation</b>			
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.371968	1.00
<b>Medicaid (see instructions for each line)</b>			
2.00	Net revenue from Medicaid	504,760	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	9,089,571	6.00
7.00	Medicaid cost (line 1 times line 6)	3,381,030	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)	2,876,270	8.00
<b>State Children's Health Insurance Program (SCHIP) (see instructions for each line)</b>			
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
<b>Other state or local government indigent care program (see instructions for each line)</b>			
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
<b>Uncompensated care (see instructions for each line)</b>			
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	16,813	18.00
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	2,876,270	19.00
		<b>Uninsured patients</b>	<b>Insured patients</b>
		<b>1.00</b>	<b>2.00</b>
		<b>Total (col. 1 + col. 2)</b>	<b>3.00</b>
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	5,534,591	38,273
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	2,058,691	14,236
22.00	Partial payment by patients approved for charity care	0	0
23.00	Cost of charity care (line 21 minus line 22)	2,058,691	14,236
		<b>1.00</b>	<b>24.00</b>
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)	1,078,038	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	635,018	27.00
28.00	Non-Medicare and Non-Reimbursable Medicare bad debt expense (line 26 minus line 27)	443,020	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	164,789	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)	2,237,716	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	5,113,986	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151308

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

Worksheet A

Date/Time Prepared:  
11/22/2013 12:50 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1,063,397	1,063,397	-52,522	1,010,875	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		683,622	683,622	0	683,622	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	209,290	2,268,892	2,478,182	0	2,478,182	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,075,875	2,711,289	4,787,164	52,522	4,839,686	5.00
7.00	00700	OPERATION OF PLANT	306,990	554,478	861,468	0	861,468	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	27,187	27,187	8.00
9.00	00900	HOUSEKEEPING	0	514,121	514,121	-27,187	486,934	9.00
10.00	01000	DIETARY	0	472,579	472,579	-330,717	141,862	10.00
11.00	01100	CAFETERIA	0	0	0	330,717	330,717	11.00
13.00	01300	NURSING ADMINISTRATION	184,574	12,596	197,170	0	197,170	13.00
15.00	01500	PHARMACY	331,107	1,957,849	2,288,956	-383	2,288,573	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	152,348	83,475	235,823	0	235,823	16.00
17.00	01700	SOCIAL SERVICE	97,398	19,572	116,970	0	116,970	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	1,066,285	124,850	1,191,135	-11,168	1,179,967	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	453,144	206,094	659,238	-66,190	593,048	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,154,023	1,212,736	2,366,759	0	2,366,759	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	1,180,629	1,180,629	0	1,180,629	60.00
65.00	06500	RESPIRATORY THERAPY	488,075	61,518	549,593	-2,841	546,752	65.00
66.00	06600	PHYSICAL THERAPY	408,610	25,989	434,599	0	434,599	66.00
67.00	06700	OCCUPATIONAL THERAPY	44,859	684	45,543	0	45,543	67.00
68.00	06800	SPEECH PATHOLOGY	0	33,184	33,184	0	33,184	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	60,037	60,037	90,195	150,232	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	143,306	143,306	0	143,306	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	SLEEP LAB	47,245	10,990	58,235	0	58,235	76.00
76.01	03021	ONCOLOGY	138,832	48,473	187,305	-1,034	186,271	76.01
76.02	03022	ECLIPSY	0	0	0	0	0	76.02
76.03	03023	WOUND CARE	0	0	0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	180,676	34,931	215,607	0	215,607	90.00
91.00	09100	EMERGENCY	991,052	1,145,779	2,136,831	-8,579	2,128,252	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
118.00		SUBTOTALS (SUM OF LINES 1-117)	8,330,383	14,631,070	22,961,453	0	22,961,453	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
194.01	07951	FOUNDATION	-1,025	-2,376	-3,401	0	-3,401	194.01
194.02	07952	CLINIC	0	0	0	0	0	194.02
194.03	07953	VACANT	0	0	0	0	0	194.03
200.00		TOTAL (SUM OF LINES 118-199)	8,329,358	14,628,694	22,958,052	0	22,958,052	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151308

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

Worksheet A

Date/Time Prepared:  
11/22/2013 12:50 pm

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
		6.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	-353,623	657,252	1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP	0	683,622	2.00
3.00	00300 OTHER CAPITAL RELATED COSTS	0	0	3.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	518,592	2,996,774	4.00
5.00	00500 ADMINISTRATIVE & GENERAL	337,860	5,177,546	5.00
7.00	00700 OPERATION OF PLANT	1,833	863,301	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	27,187	8.00
9.00	00900 HOUSEKEEPING	30,337	517,271	9.00
10.00	01000 DIETARY	-72,365	69,497	10.00
11.00	01100 CAFETERIA	0	330,717	11.00
13.00	01300 NURSING ADMINISTRATION	-2,050	195,120	13.00
15.00	01500 PHARMACY	-53,849	2,234,724	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	-109,136	126,687	16.00
17.00	01700 SOCIAL SERVICE	0	116,970	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS	-35,235	1,144,732	30.00
31.00	03100 INTENSIVE CARE UNIT	0	0	31.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	1,676	594,724	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	-626,211	1,740,548	54.00
56.00	05600 RADIOISOTOPE	0	0	56.00
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
60.00	06000 LABORATORY	-1,762	1,178,867	60.00
65.00	06500 RESPIRATORY THERAPY	-29,075	517,677	65.00
66.00	06600 PHYSICAL THERAPY	-9,132	425,467	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	45,543	67.00
68.00	06800 SPEECH PATHOLOGY	0	33,184	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	-3,504	146,728	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	143,306	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
76.00	03020 SLEEP LAB	-7,080	51,155	76.00
76.01	03021 ONCOLOGY	-27,500	158,771	76.01
76.02	03022 ECLIPSYS	0	0	76.02
76.03	03023 WOUND CARE	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000 CLINIC	0	215,607	90.00
91.00	09100 EMERGENCY	-160,650	1,967,602	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)			92.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
118.00	SUBTOTALS (SUM OF LINES 1-117)	-600,874	22,360,579	118.00
<b>NONREIMBURSABLE COST CENTERS</b>				
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	192.00
194.00	07950 MARKETING	203,102	203,102	194.00
194.01	07951 FOUNDATION	3,401	0	194.01
194.02	07952 CLINIC	0	0	194.02
194.03	07953 VACANT	0	0	194.03
200.00	TOTAL (SUM OF LINES 118-199)	-394,371	22,563,681	200.00

COST CENTERS USED IN COST REPORT

Provider CCN: 151308

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

Worksheet Non-CMS W

Date/Time Prepared:  
11/22/2013 12:50 pm

Cost Center Description		CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	NEW CAP REL COSTS-BLDG & FIXT	00100		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	00200		2.00
3.00	OTHER CAPITAL RELATED COSTS	00300		3.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	00400		4.00
5.00	ADMINISTRATIVE & GENERAL	00500		5.00
7.00	OPERATION OF PLANT	00700		7.00
8.00	LAUNDRY & LINEN SERVICE	00800		8.00
9.00	HOUSEKEEPING	00900		9.00
10.00	DIETARY	01000		10.00
11.00	CAFETERIA	01100		11.00
13.00	NURSING ADMINISTRATION	01300		13.00
15.00	PHARMACY	01500		15.00
16.00	MEDICAL RECORDS & LIBRARY	01600		16.00
17.00	SOCIAL SERVICE	01700		17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	ADULTS & PEDIATRICS	03000		30.00
31.00	INTENSIVE CARE UNIT	03100		31.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	OPERATING ROOM	05000		50.00
54.00	RADIOLOGY-DIAGNOSTIC	05400		54.00
56.00	RADIOISOTOPE	05600		56.00
57.00	CT SCAN	05700		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	05800		58.00
60.00	LABORATORY	06000		60.00
65.00	RESPIRATORY THERAPY	06500		65.00
66.00	PHYSICAL THERAPY	06600		66.00
67.00	OCCUPATIONAL THERAPY	06700		67.00
68.00	SPEECH PATHOLOGY	06800		68.00
69.00	ELECTROCARDIOLOGY	06900		69.00
70.00	ELECTROENCEPHALOGRAPHY	07000		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	07100		71.00
72.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	07200		72.00
73.00	DRUGS CHARGED TO PATIENTS	07300		73.00
76.00	SLEEP LAB	03020		76.00
76.01	ONCOLOGY	03021		76.01
76.02	ECLIPSYS	03022		76.02
76.03	WOUND CARE	03023		76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	CLINIC	09000		90.00
91.00	EMERGENCY	09100		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	09200		92.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
118.00	SUBTOTALS (SUM OF LINES 1-117)			118.00
<b>NONREIMBURSABLE COST CENTERS</b>				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	19000		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	19200		192.00
194.00	MARKETING	07950		194.00
194.01	FOUNDATION	07951		194.01
194.02	CLINIC	07952		194.02
194.03	VACANT	07953		194.03
200.00	TOTAL (SUM OF LINES 118-199)			200.00

		Increases				
		Cost Center	Line #	Salary	Other	
		2.00	3.00	4.00	5.00	
<b>A - CAFETERIA</b>						
1.00	CAFETERIA		11.00	0	330,717	1.00
	TOTALS			0	330,717	
<b>B - LAUNDRY</b>						
1.00	LAUNDRY & LINEN SERVICE		8.00	0	27,187	1.00
	TOTALS			0	27,187	
<b>C - INTEREST</b>						
1.00	ADMINISTRATIVE & GENERAL		5.00	0	52,522	1.00
	TOTALS			0	52,522	
<b>F - BILLABLE MED SUPPLIES</b>						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS		71.00	0	90,195	1.00
2.00			0.00	0	0	2.00
3.00			0.00	0	0	3.00
4.00			0.00	0	0	4.00
5.00			0.00	0	0	5.00
6.00			0.00	0	0	6.00
	TOTALS			0	90,195	
500.00	Grand Total: Increases			0	500,621	500.00

Provider CCN: 151308

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

Worksheet A-6  
Date/Time Prepared:  
11/22/2013 12:50 pm

		Decreases				
	Cost Center	Line #	Salary	Other	wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
<b>A - CAFETERIA</b>						
1.00	DIETARY	10.00	0	330,717	0	1.00
	TOTALS		0	330,717		
<b>B - LAUNDRY</b>						
1.00	HOUSEKEEPING	9.00	0	27,187	0	1.00
	TOTALS		0	27,187		
<b>C - INTEREST</b>						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	52,522	9	1.00
	TOTALS		0	52,522		
<b>F - BILLABLE MED SUPPLIES</b>						
1.00	PHARMACY	15.00	0	383	0	1.00
2.00	ADULTS & PEDIATRICS	30.00	0	11,168	0	2.00
3.00	OPERATING ROOM	50.00	0	66,190	0	3.00
4.00	RESPIRATORY THERAPY	65.00	0	2,841	0	4.00
5.00	ONCOLOGY	76.01	0	1,034	0	5.00
6.00	EMERGENCY	91.00	0	8,579	0	6.00
	TOTALS		0	90,195		
500.00	Grand Total: Decreases		0	500,621		500.00

Increases			Decreases			
Cost Center	Line #	Salary	Cost Center	Line #	Salary	
2.00	3.00	4.00	6.00	7.00	8.00	
<b>A - CAFETERIA</b>						
1.00			0			1.00
	11.00		0	10.00		
			0			
<b>B - LAUNDRY</b>						
1.00			0			1.00
	8.00		0	9.00		
			0			
<b>C - INTEREST</b>						
1.00			0			1.00
	5.00		0	1.00		
			0			
<b>F - BILLABLE MED SUPPLIES</b>						
1.00			0			1.00
	71.00		0	15.00		
2.00			0			2.00
	0.00		0	30.00		
3.00			0			3.00
	0.00		0	50.00		
4.00			0			4.00
	0.00		0	65.00		
5.00			0			5.00
	0.00		0	76.01		
6.00			0			6.00
	0.00		0	91.00		
			0			
500.00			0			500.00
			0			
Grand Total: Increases			Grand Total: Decreases			

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151308

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

Worksheet A-7  
Part I  
Date/Time Prepared:  
11/22/2013 12:50 pm

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	457,300	0	0	0	1.00
2.00	Land Improvements	537,417	0	0	0	2.00
3.00	Buildings and Fixtures	28,105,007	422,844	0	422,844	3.00
4.00	Building Improvements	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	5.00
6.00	Movable Equipment	0	0	0	0	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	29,099,724	422,844	0	422,844	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	29,099,724	422,844	0	422,844	10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	457,300	0			1.00
2.00	Land Improvements	537,417	0			2.00
3.00	Buildings and Fixtures	28,527,851	0			3.00
4.00	Building Improvements	0	0			4.00
5.00	Fixed Equipment	0	0			5.00
6.00	Movable Equipment	0	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	29,522,568	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	29,522,568	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151308

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

Worksheet A-7  
Part II  
Date/Time Prepared:  
11/22/2013 12:50 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
<b>PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2</b>							
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,063,397	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	683,622	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,747,019	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
<b>PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2</b>							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	1,063,397				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	683,622				2.00
3.00	Total (sum of lines 1-2)	0	1,747,019				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151308

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

Worksheet A-7  
Part III  
Date/Time Prepared:  
11/22/2013 12:50 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
<b>PART III - RECONCILIATION OF CAPITAL COSTS CENTERS</b>							
1.00	NEW CAP REL COSTS-BLDG & FIXT	29,522,568	0	29,522,568	1.000000	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	29,522,568	0	29,522,568	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
<b>PART III - RECONCILIATION OF CAPITAL COSTS CENTERS</b>							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	657,252	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	683,622	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,340,874	0	3.00
Cost Center Description		SUMMARY OF CAPITAL			SUMMARY OF CAPITAL		
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
<b>PART III - RECONCILIATION OF CAPITAL COSTS CENTERS</b>							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	657,252	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	683,622	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	1,340,874	3.00

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 - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-204,865	NEW CAP REL COSTS-BLDG & FIXT		1.00	9	1.00
2.00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP		2.00	0	2.00
3.00 Investment income - other (chapter 2)	B	-30,428	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)	A	-7,399	ADMINISTRATIVE & GENERAL		5.00	0	7.00
8.00 Television and radio service (chapter 21)	A	-2,484	ADMINISTRATIVE & GENERAL		5.00	0	8.00
9.00 Parking lot (chapter 21)		0			0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-815,465				0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0			0.00	0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	1,849,379				0	12.00
13.00 Laundry and linen service		0			0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-72,526	DIETARY		10.00	0	14.00
15.00 Rental of quarters to employee and others		0			0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients		0			0.00	0	16.00
17.00 Sale of drugs to other than patients	B	-49,562	PHARMACY		15.00	0	17.00
18.00 Sale of medical records and abstracts	B	-8,526	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 - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT		1.00	0	26.00
27.00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP		2.00	0	27.00
28.00 Non-physician Anesthetist		0	*** Cost Center Deleted ***		19.00		28.00
29.00 Physicians' assistant		0			0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY		67.00		30.00
30.99 Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS		30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY		68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0			0.00	0	32.00

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Provider CCN: 151308

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

Worksheet A-8

Date/Time Prepared:  
11/22/2013 12:50 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on worksheet A To/From which the Amount is to be Adjusted			wkst. A-7 Ref.
			Cost Center		Line #	
			1.00	2.00	3.00	
33.00 FOUNDATION ADJUSTMENT	B	3,401	FOUNDATION		194.01	0 33.00
33.01 LAB REVENUE	B	-1,762	LABORATORY		60.00	0 33.01
33.02 PT REVENUE	B	-9,132	PHYSICAL THERAPY		66.00	0 33.02
33.03 FOOD SERVICES REVENUE	B	-18	DIETARY		10.00	0 33.03
34.00 ADMIN REVENUE	B	-18,654	ADMINISTRATIVE & GENERAL		5.00	0 34.00
35.00 RT REVENUE	B	-275	RESPIRATORY THERAPY		65.00	0 35.00
35.01 NURSING ADMIN REVENUE	B	-2,050	NURSING ADMINISTRATION		13.00	0 35.01
36.00 LOBBYING	A	-665	ADMINISTRATIVE & GENERAL		5.00	0 36.00
37.00 PHYSICIAN RECRUITMENT	A	-10,000	ADMINISTRATIVE & GENERAL		5.00	0 37.00
38.00		0			0.00	0 38.00
39.00		0			0.00	0 39.00
40.00		0			0.00	0 40.00
41.00		0			0.00	0 41.00
42.00 PROVIDER TAX	A	-969,394	ADMINISTRATIVE & GENERAL		5.00	0 42.00
42.04		0			0.00	0 42.04
42.05		0			0.00	0 42.05
42.06 GIFTS/DONATIONS EXPENSE	A	-15,223	ADMINISTRATIVE & GENERAL		5.00	0 42.06
42.09 ENTERTAINMENT	A	908	ADMINISTRATIVE & GENERAL		5.00	0 42.09
42.10 RADIOLOGY PURCHASED SVCS	A	-29,631	RADIOLOGY-DIAGNOSTIC		54.00	0 42.10
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200.)		-394,371				50.00

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

Provider CCN: 151308

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

Worksheet A-8-1

Date/Time Prepared: 11/22/2013 12:50 pm

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED</b>					
<b>HOME OFFICE COSTS:</b>					
1.00	0.00		0	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL HOME OFFICE	3,996,628	1,295,054	2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT HOME OFFICE - BENEFITS	0	86,210	3.00
3.01	194.00	MARKETING HOME OFFICE	203,102	0	3.01
4.00	5.00	ADMINISTRATIVE & GENERAL HOME OFFICE EXECUTIVE PAY	0	120,575	4.00
4.01	7.00	OPERATION OF PLANT ST. VINCENT HEALTH - CHG	0	-1,833	4.01
4.02	65.00	RESPIRATORY THERAPY ST. VINCENT HEALTH - CHG	0	28,800	4.02
4.03	71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS ST. VINCENT HEALTH - CHG	0	3,504	4.03
4.04	9.00	HOUSEKEEPING ST. VINCENT HEALTH - CHG	0	-30,337	4.04
4.05	10.00	DIETARY ST. VINCENT HEALTH - CHG	0	-179	4.05
4.06	15.00	PHARMACY ST. VINCENT HEALTH - CHG	0	4,287	4.06
4.07	16.00	MEDICAL RECORDS & LIBRARY ST. VINCENT HEALTH - CHG	0	100,610	4.07
4.08	54.00	RADIOLOGY-DIAGNOSTIC ST. VINCENT HEALTH - CHG	0	19,090	4.08
4.09	4.00	EMPLOYEE BENEFITS DEPARTMENT ST. VINCENT HEALTH - CHG	0	236,191	4.09
4.10	5.00	ADMINISTRATIVE & GENERAL ST. VINCENT HEALTH - CHG	0	1,167,706	4.10
4.11	50.00	OPERATING ROOM ST. VINCENT HEALTH - CHG	0	-1,676	4.11
4.16	1.00	NEW CAP REL COSTS-BLDG & FIXT ASCENSION INTEREST	204,865	353,623	4.16
4.17	5.00	ADMINISTRATIVE & GENERAL ASCENSION INTEREST	30,428	52,522	4.17
4.19	54.00	RADIOLOGY-DIAGNOSTIC ASCENSION MAINTENANCE	527,476	519,966	4.19
4.23	4.00	EMPLOYEE BENEFITS DEPARTMENT SELF INSURANCE	2,063,439	1,313,262	4.23
4.24	4.00	EMPLOYEE BENEFITS DEPARTMENT PENSION	210,747	119,931	4.24
5.00	0		7,236,685	5,387,306	5.00

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

symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office	
			Name	Percentage of Ownership
1.00	2.00	3.00	4.00	5.00
<b>B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:</b>				

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	B	ST. VINCENT HEA	100.00	ST. VINCENT HEALTH	100.00	6.00
7.00	B	ASCENSION	100.00	ASCENSION	100.00	7.00
8.00	B	ST. VINCENT HOS	100.00	ST. VINCENT HOSPITAL	100.00	8.00
9.00	A	TRIMEDX	0.00	TRIMEDX	0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. other (financial or non-financial) specify:					100.00

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

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

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

Provider CCN: 151308

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

Worksheet A-8-1  
Date/Time Prepared:  
11/22/2013 12:50 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	6.00	7.00	
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>			
1.00	0	0	1.00
2.00	2,701,574	0	2.00
3.00	-86,210	0	3.00
3.01	203,102	0	3.01
4.00	-120,575	0	4.00
4.01	1,833	0	4.01
4.02	-28,800	0	4.02
4.03	-3,504	0	4.03
4.04	30,337	0	4.04
4.05	179	0	4.05
4.06	-4,287	0	4.06
4.07	-100,610	0	4.07
4.08	-19,090	0	4.08
4.09	-236,191	0	4.09
4.10	-1,167,706	0	4.10
4.11	1,676	0	4.11
4.16	-148,758	9	4.16
4.17	-22,094	0	4.17
4.19	7,510	0	4.19
4.23	750,177	0	4.23
4.24	90,816	0	4.24
5.00	1,849,379		5.00

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

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151308

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

Worksheet A-8-2

Date/Time Prepared:  
11/22/2013 12:50 pm

	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
Wkst. A Line #	Cost Center/Physician Identifier		Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
1.00	91.00	EMERGENCY	1,046,901	160,650	886,251	0	0	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	76.01	ONCOLOGY	27,500	27,500	0	0	0	3.00
4.00	76.00	SLEEP LAB	7,080	7,080	0	0	0	4.00
5.00	30.00	ADULTS & PEDIATRICS	35,235	35,235	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	585,000	585,000	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			1,701,716	815,465	886,251	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	91.00	EMERGENCY	0	0	0	0	0	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	76.01	ONCOLOGY	0	0	0	0	0	3.00
4.00	76.00	SLEEP LAB	0	0	0	0	0	4.00
5.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	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	91.00	EMERGENCY	0	0	0	160,650		1.00
2.00	0.00		0	0	0	0		2.00
3.00	76.01	ONCOLOGY	0	0	0	27,500		3.00
4.00	76.00	SLEEP LAB	0	0	0	7,080		4.00
5.00	30.00	ADULTS & PEDIATRICS	0	0	0	35,235		5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	585,000		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	815,465		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY PROVIDER CCN: 151308 Period: From 07/01/2012 To 06/30/2013 Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/22/2013 12:50 pm

		Speech Pathology					Cost	
							1.00	
<b>PART I - GENERAL INFORMATION</b>								
1.00	Total number of weeks worked (excluding aides) (see instructions)						77	1.00
2.00	Line 1 multiplied by 15 hours per week						1,155	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)						166	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)						0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)						0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)						0	6.00
7.00	Standard travel expense rate						5.21	7.00
8.00	Optional travel expense rate per mile						0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees		
		1.00	2.00	3.00	4.00	5.00		
9.00	Total hours worked	0.00	332.00	0.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	68.26	0.00	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	34.13	34.13	0.00				11.00
12.00	Number of travel hours (provider site)	0	0	0				12.00
12.01	Number of travel hours (offsite)	0	0	0				12.01
13.00	Number of miles driven (provider site)	0	0	0				13.00
13.01	Number of miles driven (offsite)	0	0	0				13.01
							1.00	
<b>Part II - SALARY EQUIVALENCY COMPUTATION</b>								
14.00	Supervisors (column 1, line 9 times column 1, line 10)						0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)						22,662	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)						0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)						22,662	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)						0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)						0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)						22,662	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.								
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)						68.26	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)						78,840	22.00
23.00	Total salary equivalency (see instructions)						78,840	23.00
<b>PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE</b>								
<b>Standard Travel Allowance</b>								
24.00	Therapists (line 3 times column 2, line 11)						5,666	24.00
25.00	Assistants (line 4 times column 3, line 11)						0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)						5,666	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)						865	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)						6,531	28.00
<b>Optional Travel Allowance and Optional Travel Expense</b>								
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)						0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)						0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)						0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)						0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)						0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)						0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)						0	35.00
<b>Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE</b>								
<b>Standard Travel Expense</b>								
36.00	Therapists (line 5 times column 2, line 11)						0	36.00
37.00	Assistants (line 6 times column 3, line 11)						0	37.00
38.00	Subtotal (sum of lines 36 and 37)						0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)						0	39.00
<b>Optional Travel Allowance and Optional Travel Expense</b>								
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)						0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)						0	41.00
42.00	Subtotal (sum of lines 40 and 41)						0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)						0	43.00
<b>Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.</b>								
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)						0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)						0	45.00

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 151308	Period: From 07/01/2012 To 06/30/2013	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/22/2013 12:50 pm
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Speech Pathology	Cost	1.00	0	46.00
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46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)								
		Therapists	Assistants	Aides	Trainees	Total			
		1.00	2.00	3.00	4.00	5.00			

**PART V - OVERTIME COMPUTATION**

47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00	0.00	0.00	48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00	0.00	0.00	49.00

**CALCULATION OF LIMIT**

50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	0.00	51.00

**DETERMINATION OF OVERTIME ALLOWANCE**

52.00	Adjusted hourly salary equivalency amount (see instructions)	68.26	0.00	0.00	0.00	0.00	0.00	52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0	0	0	53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0	0	0	54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0	0	0	55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	0	56.00

1.00

**Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT**

57.00	Salary equivalency amount (from line 23)						78,840	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))						0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)						0	59.00
60.00	Overtime allowance (from column 5, line 56)						0	60.00
61.00	Equipment cost (see instructions)						0	61.00
62.00	Supplies (see instructions)						0	62.00
63.00	Total allowance (sum of lines 57-62)						78,840	63.00
64.00	Total cost of outside supplier services (from your records)						34,460	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)						0	65.00

**LINE 33 CALCULATION**

100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others						5,666	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						865	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27						6,531	100.02

**LINE 34 CALCULATION**

101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						865	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	101.01
101.02	Line 34 = sum of lines 27 and 31						865	101.02

**LINE 35 CALCULATION**

102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others						0	102.01
102.02	Line 35 = sum of lines 31 and 32						0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151308

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

Worksheet B  
Part I  
Date/Time Prepared:  
11/22/2013 12:50 pm

Cost Center Description	Net Expenses for Cost Allocation (from wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
		1.00	2.00			4.00
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	657,252	657,252		1.00	
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP	683,622		683,622	2.00	
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	2,996,774	4,704	207	3,001,685	
5.00 00500	ADMINISTRATIVE & GENERAL	5,177,546	244,376	34,626	801,549	6,258,097
7.00 00700	OPERATION OF PLANT	863,301	100,615	22,389	118,537	1,104,842
8.00 00800	LAUNDRY & LINEN SERVICE	27,187	7,829	0	0	35,016
9.00 00900	HOUSEKEEPING	517,271	4,772	0	0	522,043
10.00 01000	DIETARY	69,497	12,983	4,495	0	86,975
11.00 01100	CAFETERIA	330,717	8,234	0	0	338,951
13.00 01300	NURSING ADMINISTRATION	195,120	9,487	3,331	71,269	279,207
15.00 01500	PHARMACY	2,234,724	7,301	40,941	127,849	2,410,815
16.00 01600	MEDICAL RECORDS & LIBRARY	126,687	11,437	0	58,826	196,950
17.00 01700	SOCIAL SERVICE	116,970	2,254	20	37,608	156,852
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	1,144,732	44,738	115,464	438,592	1,743,526
31.00 03100	INTENSIVE CARE UNIT	0	0	0	0	0
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	594,724	43,923	116,429	59,133	814,209
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,740,548	28,197	284,628	445,598	2,498,971
56.00 05600	RADIOISOTOPE	0	0	0	0	0
57.00 05700	CT SCAN	0	0	0	0	0
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
60.00 06000	LABORATORY	1,178,867	12,348	0	0	1,191,215
65.00 06500	RESPIRATORY THERAPY	517,677	13,736	13,541	188,458	733,412
66.00 06600	PHYSICAL THERAPY	425,467	28,967	1,887	157,775	614,096
67.00 06700	OCCUPATIONAL THERAPY	45,543	1,023	0	17,321	63,887
68.00 06800	SPEECH PATHOLOGY	33,184	0	0	0	33,184
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	0
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	146,728	0	0	0	146,728
72.00 07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	143,306	0	0	0	143,306
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
76.00 03020	SLEEP LAB	51,155	0	13,876	0	65,031
76.01 03021	ONCOLOGY	158,771	1,945	3,029	53,607	217,352
76.02 03022	ECLIPSYS	0	0	0	0	0
76.03 03023	WOUND CARE	0	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	215,607	8,133	864	42,892	267,496
91.00 09100	EMERGENCY	1,967,602	40,562	27,895	382,671	2,418,730
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					0
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1-117)	22,360,579	637,564	683,622	3,001,685	22,340,891
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,905	0	0	1,905
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	8,048	0	0	8,048
194.00 07950	MARKETING	203,102	4,131	0	0	207,233
194.01 07951	FOUNDATION	0	1,748	0	0	1,748
194.02 07952	CLINIC	0	0	0	0	0
194.03 07953	VACANT	0	3,856	0	0	3,856
200.00	Cross Foot Adjustments					0
201.00	Negative Cost Centers		0	0	0	0
202.00	TOTAL (sum lines 118-201)	22,563,681	657,252	683,622	3,001,685	22,563,681

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151308

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

Worksheet B  
Part I  
Date/Time Prepared:  
11/22/2013 12:50 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,258,097				5.00
7.00	00700	OPERATION OF PLANT	424,039	1,528,881			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	13,439	38,919	87,374		8.00
9.00	00900	HOUSEKEEPING	200,361	23,720	18,064	764,188	9.00
10.00	01000	DIETARY	33,381	64,539	1,124	507	186,526
11.00	01100	CAFETERIA	130,090	40,931	1,736	0	0
13.00	01300	NURSING ADMINISTRATION	107,160	47,161	0	9,635	0
15.00	01500	PHARMACY	925,273	36,293	0	25,862	0
16.00	01600	MEDICAL RECORDS & LIBRARY	75,590	56,856	0	3,550	0
17.00	01700	SOCIAL SERVICE	60,200	11,204	0	10,142	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	669,167	222,395	28,854	260,135	186,526
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	312,494	218,344	9,367	64,908	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	959,105	140,170	7,079	85,699	0
56.00	05600	RADIOISOTOPE	0	0	0	0	0
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
60.00	06000	LABORATORY	457,190	61,382	0	22,819	0
65.00	06500	RESPIRATORY THERAPY	281,484	68,283	0	53,245	0
66.00	06600	PHYSICAL THERAPY	235,691	143,998	4,568	80,121	0
67.00	06700	OCCUPATIONAL THERAPY	24,520	5,085	0	0	0
68.00	06800	SPEECH PATHOLOGY	12,736	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	56,314	0	0	0	0
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	55,001	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
76.00	03020	SLEEP LAB	24,959	0	1,423	15,213	0
76.01	03021	ONCOLOGY	83,420	9,667	0	24,848	0
76.02	03022	ECLIPSYS	0	0	0	0	0
76.03	03023	WOUND CARE	0	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	102,665	40,428	2,863	0	0
91.00	09100	EMERGENCY	928,311	201,636	12,296	91,784	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		SUBTOTALS (SUM OF LINES 1-117)	6,172,590	1,431,011	87,374	748,468	186,526
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	731	9,471	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,089	40,009	0	0	0
194.00	07950	MARKETING	79,536	20,535	0	5,071	0
194.01	07951	FOUNDATION	671	8,689	0	10,649	0
194.02	07952	CLINIC	0	0	0	0	0
194.03	07953	VACANT	1,480	19,166	0	0	0
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	6,258,097	1,528,881	87,374	764,188	186,526

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151308

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

Worksheet B  
Part I  
Date/Time Prepared:  
11/22/2013 12:50 pm

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		11.00	13.00	15.00	16.00	17.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	511,708					11.00
13.00	01300	11,744	454,907				13.00
15.00	01500	21,211	20,257	3,439,711			15.00
16.00	01600	22,594	0	0	355,540		16.00
17.00	01700	7,435	7,101	0	0	252,934	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	114,592	114,461	0	19,508	245,331	30.00
31.00	03100	0	0	0	0	0	31.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	41,790	39,910	0	52,825	0	50.00
54.00	05400	89,770	85,728	0	111,698	0	54.00
56.00	05600	0	0	0	0	0	56.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
60.00	06000	0	0	0	60,399	0	60.00
65.00	06500	43,371	41,419	0	13,873	0	65.00
66.00	06600	35,227	33,642	0	14,007	0	66.00
67.00	06700	3,075	2,936	0	1,560	0	67.00
68.00	06800	0	0	0	829	0	68.00
69.00	06900	0	0	0	0	0	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	3,439,711	0	0	73.00
76.00	03020	3,318	3,168	0	3,543	0	76.00
76.01	03021	10,366	9,900	0	5,656	0	76.01
76.02	03022	0	0	0	0	0	76.02
76.03	03023	0	0	0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	18,989	12,406	0	3,681	0	90.00
91.00	09100	88,226	83,979	0	67,961	7,603	91.00
92.00	09200						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		511,708	454,907	3,439,711	355,540	252,934	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		511,708	454,907	3,439,711	355,540	252,934	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151308

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

Worksheet B  
Part I  
Date/Time Prepared:  
11/22/2013 12:50 pm

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	NEW 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
17.00	01700	SOCIAL SERVICE			17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	3,604,495	0	3,604,495
31.00	03100	INTENSIVE CARE UNIT	0	0	0
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	1,553,847	0	1,553,847
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,978,220	0	3,978,220
56.00	05600	RADIOISOTOPE	0	0	0
57.00	05700	CT SCAN	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0
60.00	06000	LABORATORY	1,793,005	0	1,793,005
65.00	06500	RESPIRATORY THERAPY	1,235,087	0	1,235,087
66.00	06600	PHYSICAL THERAPY	1,161,350	0	1,161,350
67.00	06700	OCCUPATIONAL THERAPY	101,063	0	101,063
68.00	06800	SPEECH PATHOLOGY	46,749	0	46,749
69.00	06900	ELECTROCARDIOLOGY	0	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	203,042	0	203,042
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	198,307	0	198,307
73.00	07300	DRUGS CHARGED TO PATIENTS	3,439,711	0	3,439,711
76.00	03020	SLEEP LAB	116,655	0	116,655
76.01	03021	ONCOLOGY	361,209	0	361,209
76.02	03022	ECLIPSYS	0	0	0
76.03	03023	WOUND CARE	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	448,528	0	448,528
91.00	09100	EMERGENCY	3,900,526	0	3,900,526
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0	
<b>SPECIAL PURPOSE COST CENTERS</b>					
118.00	SUBTOTALS (SUM OF LINES 1-117)		22,141,794	0	22,141,794
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	12,107	0	12,107
192.00	19200	PHYSICIANS' PRIVATE OFFICES	51,146	0	51,146
194.00	07950	MARKETING	312,375	0	312,375
194.01	07951	FOUNDATION	21,757	0	21,757
194.02	07952	CLINIC	0	0	0
194.03	07953	VACANT	24,502	0	24,502
200.00		Cross Foot Adjustments	0	0	0
201.00		Negative Cost Centers	0	0	0
202.00		TOTAL (sum lines 118-201)	22,563,681	0	22,563,681

Provider CCN: 151308

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

Worksheet Non-CMS W  
 Date/Time Prepared:  
 11/22/2013 12:50 pm

Cost Center Description		Statistics	Statistics	Description	
		Code			
		1.00	2.00		
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	NEW CAP REL COSTS-BLDG & FIXT	3	SQUARE	FEET	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2	DIRECT COST		2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	4	GROSS SALARIES		4.00
5.00	ADMINISTRATIVE & GENERAL	-23	ACCUM. COST		5.00
7.00	OPERATION OF PLANT	3	SQUARE	FEET	7.00
8.00	LAUNDRY & LINEN SERVICE	8	POUNDS OF	LAUNDRY	8.00
9.00	HOUSEKEEPING	9	HOURS OF	SERVICE	9.00
10.00	DIETARY	10	PATIENT	DAYS	10.00
11.00	CAFETERIA	11	HOURS		11.00
13.00	NURSING ADMINISTRATION	13	DIRECT	NRSING HRS	13.00
15.00	PHARMACY	15	COSTED REQUIS.		15.00
16.00	MEDICAL RECORDS & LIBRARY	16	GROSS CHARGES		16.00
17.00	SOCIAL SERVICE	17	TIME SPENT		17.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151308

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

Worksheet B  
Part II  
Date/Time Prepared:  
11/22/2013 12:50 pm

Cost Center Description	CAPITAL RELATED COSTS				Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
	Directly Assigned New Capital Related Costs	NEW BLDG & FIXT	NEW MVBLE EQUIP				
		0	1.00	2.00			
<b>GENERAL SERVICE COST CENTERS</b>							
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	4,704	207	4,911	4,911	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	325,417	244,376	34,626	604,419	1,311	5.00
7.00 00700	OPERATION OF PLANT	0	100,615	22,389	123,004	194	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	7,829	0	7,829	0	8.00
9.00 00900	HOUSEKEEPING	0	4,772	0	4,772	0	9.00
10.00 01000	DIETARY	0	12,983	4,495	17,478	0	10.00
11.00 01100	CAFETERIA	0	8,234	0	8,234	0	11.00
13.00 01300	NURSING ADMINISTRATION	0	9,487	3,331	12,818	117	13.00
15.00 01500	PHARMACY	0	7,301	40,941	48,242	209	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	11,437	0	11,437	96	16.00
17.00 01700	SOCIAL SERVICE	0	2,254	20	2,274	62	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00 03000	ADULTS & PEDIATRICS	0	44,738	115,464	160,202	718	30.00
31.00 03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 05000	OPERATING ROOM	0	43,923	116,429	160,352	97	50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	28,197	284,628	312,825	729	54.00
56.00 05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00 05700	CT SCAN	0	0	0	0	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00 06000	LABORATORY	0	12,348	0	12,348	0	60.00
65.00 06500	RESPIRATORY THERAPY	0	13,736	13,541	27,277	308	65.00
66.00 06600	PHYSICAL THERAPY	0	28,967	1,887	30,854	258	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	1,023	0	1,023	28	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00 03020	SLEEP LAB	0	0	13,876	13,876	0	76.00
76.01 03021	ONCOLOGY	0	1,945	3,029	4,974	88	76.01
76.02 03022	ECLIPSYS	0	0	0	0	0	76.02
76.03 03023	WOUND CARE	0	0	0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00 09000	CLINIC	0	8,133	864	8,997	70	90.00
91.00 09100	EMERGENCY	0	40,562	27,895	68,457	626	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00	SUBTOTALS (SUM OF LINES 1-117)	325,417	637,564	683,622	1,646,603	4,911	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,905	0	1,905	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	8,048	0	8,048	0	192.00
194.00 07950	MARKETING	0	4,131	0	4,131	0	194.00
194.01 07951	FOUNDATION	0	1,748	0	1,748	0	194.01
194.02 07952	CLINIC	0	0	0	0	0	194.02
194.03 07953	VACANT	0	3,856	0	3,856	0	194.03
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)	325,417	657,252	683,622	1,666,291	4,911	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151308

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

Worksheet B  
Part II  
Date/Time Prepared:  
11/22/2013 12:50 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	605,730				5.00
7.00	00700	OPERATION OF PLANT	41,044	164,242			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,301	4,181	13,311		8.00
9.00	00900	HOUSEKEEPING	19,393	2,548	2,752	29,465	9.00
10.00	01000	DIETARY	3,231	6,933	171	20	27,833
11.00	01100	CAFETERIA	12,592	4,397	265	0	0
13.00	01300	NURSING ADMINISTRATION	10,372	5,066	0	371	0
15.00	01500	PHARMACY	89,559	3,899	0	997	0
16.00	01600	MEDICAL RECORDS & LIBRARY	7,316	6,108	0	137	0
17.00	01700	SOCIAL SERVICE	5,827	1,204	0	391	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	64,770	23,893	4,396	10,029	27,833
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	30,247	23,456	1,427	2,503	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	92,830	15,058	1,078	3,304	0
56.00	05600	RADIOISOTOPE	0	0	0	0	0
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
60.00	06000	LABORATORY	44,252	6,594	0	880	0
65.00	06500	RESPIRATORY THERAPY	27,246	7,335	0	2,053	0
66.00	06600	PHYSICAL THERAPY	22,813	15,469	696	3,089	0
67.00	06700	OCCUPATIONAL THERAPY	2,373	546	0	0	0
68.00	06800	SPEECH PATHOLOGY	1,233	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,451	0	0	0	0
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	5,324	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
76.00	03020	SLEEP LAB	2,416	0	217	587	0
76.01	03021	ONCOLOGY	8,074	1,038	0	958	0
76.02	03022	ECLIPSYS	0	0	0	0	0
76.03	03023	WOUND CARE	0	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	9,937	4,343	436	0	0
91.00	09100	EMERGENCY	89,853	21,661	1,873	3,539	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00	SUBTOTALS (SUM OF LINES 1-117)		597,454	153,729	13,311	28,858	27,833
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	71	1,017	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	299	4,298	0	0	0
194.00	07950	MARKETING	7,698	2,206	0	196	0
194.01	07951	FOUNDATION	65	933	0	411	0
194.02	07952	CLINIC	0	0	0	0	0
194.03	07953	VACANT	143	2,059	0	0	0
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	605,730	164,242	13,311	29,465	27,833

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151308

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

Worksheet B  
Part II  
Date/Time Prepared:  
11/22/2013 12:50 pm

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE		
		11.00	13.00	15.00	16.00	17.00		
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100						1.00	
2.00	00200						2.00	
4.00	00400						4.00	
5.00	00500						5.00	
7.00	00700						7.00	
8.00	00800						8.00	
9.00	00900						9.00	
10.00	01000						10.00	
11.00	01100	25,488					11.00	
13.00	01300	585	29,329				13.00	
15.00	01500	1,057	1,306	145,269			15.00	
16.00	01600	1,125	0	0	26,219		16.00	
17.00	01700	370	458	0	0	10,586	17.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	5,708	7,381	0	1,440	10,268	30.00	
31.00	03100	0	0	0	0	0	31.00	
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	2,082	2,573	0	3,899	0	50.00	
54.00	05400	4,471	5,527	0	8,221	0	54.00	
56.00	05600	0	0	0	0	0	56.00	
57.00	05700	0	0	0	0	0	57.00	
58.00	05800	0	0	0	0	0	58.00	
60.00	06000	0	0	0	4,458	0	60.00	
65.00	06500	2,160	2,670	0	1,024	0	65.00	
66.00	06600	1,755	2,169	0	1,034	0	66.00	
67.00	06700	153	189	0	115	0	67.00	
68.00	06800	0	0	0	61	0	68.00	
69.00	06900	0	0	0	0	0	69.00	
70.00	07000	0	0	0	0	0	70.00	
71.00	07100	0	0	0	0	0	71.00	
72.00	07200	0	0	0	0	0	72.00	
73.00	07300	0	0	145,269	0	0	73.00	
76.00	03020	165	204	0	262	0	76.00	
76.01	03021	516	638	0	417	0	76.01	
76.02	03022	0	0	0	0	0	76.02	
76.03	03023	0	0	0	0	0	76.03	
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	946	800	0	272	0	90.00	
91.00	09100	4,395	5,414	0	5,016	318	91.00	
92.00	09200						92.00	
<b>SPECIAL PURPOSE COST CENTERS</b>								
118.00	SUBTOTALS (SUM OF LINES 1-117)		25,488	29,329	145,269	26,219	10,586	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	0	0	0	0	0	190.00	
192.00	19200	0	0	0	0	0	192.00	
194.00	07950	0	0	0	0	0	194.00	
194.01	07951	0	0	0	0	0	194.01	
194.02	07952	0	0	0	0	0	194.02	
194.03	07953	0	0	0	0	0	194.03	
200.00	Cross Foot Adjustments						200.00	
201.00	Negative Cost Centers						201.00	
202.00	TOTAL (sum lines 118-201)		25,488	29,329	145,269	26,219	10,586	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151308

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

Worksheet B  
Part II  
Date/Time Prepared:  
11/22/2013 12:50 pm

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100				1.00
2.00	00200				2.00
4.00	00400				4.00
5.00	00500				5.00
7.00	00700				7.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
13.00	01300				13.00
15.00	01500				15.00
16.00	01600				16.00
17.00	01700				17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	316,638	0	316,638	30.00
31.00	03100	0	0	0	31.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	226,636	0	226,636	50.00
54.00	05400	444,043	0	444,043	54.00
56.00	05600	0	0	0	56.00
57.00	05700	0	0	0	57.00
58.00	05800	0	0	0	58.00
60.00	06000	68,532	0	68,532	60.00
65.00	06500	70,073	0	70,073	65.00
66.00	06600	78,137	0	78,137	66.00
67.00	06700	4,427	0	4,427	67.00
68.00	06800	1,294	0	1,294	68.00
69.00	06900	0	0	0	69.00
70.00	07000	0	0	0	70.00
71.00	07100	5,451	0	5,451	71.00
72.00	07200	5,324	0	5,324	72.00
73.00	07300	145,269	0	145,269	73.00
76.00	03020	17,727	0	17,727	76.00
76.01	03021	16,703	0	16,703	76.01
76.02	03022	0	0	0	76.02
76.03	03023	0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	25,801	0	25,801	90.00
91.00	09100	201,152	0	201,152	91.00
92.00	09200		0		92.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
118.00		1,627,207	0	1,627,207	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	2,993	0	2,993	190.00
192.00	19200	12,645	0	12,645	192.00
194.00	07950	14,231	0	14,231	194.00
194.01	07951	3,157	0	3,157	194.01
194.02	07952	0	0	0	194.02
194.03	07953	6,058	0	6,058	194.03
200.00		0	0	0	200.00
201.00		0	0	0	201.00
202.00		1,666,291	0	1,666,291	202.00

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DIRECT COST)					
	1.00	2.00	4.00				
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	116,942				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		683,621			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	837	207	7,773,849		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	43,481	34,626	2,075,875	-6,258,097	5.00
7.00	00700	OPERATION OF PLANT	17,902	22,389	306,990	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,393	0	0	0	8.00
9.00	00900	HOUSEKEEPING	849	0	0	0	9.00
10.00	01000	DIETARY	2,310	4,495	0	0	10.00
11.00	01100	CAFETERIA	1,465	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,688	3,331	184,574	0	13.00
15.00	01500	PHARMACY	1,299	40,941	331,107	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,035	0	152,348	0	16.00
17.00	01700	SOCIAL SERVICE	401	20	97,398	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	7,960	115,464	1,135,878	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	7,815	116,429	153,144	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,017	284,627	1,154,023	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
60.00	06000	LABORATORY	2,197	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	2,444	13,541	488,075	0	65.00
66.00	06600	PHYSICAL THERAPY	5,154	1,887	408,610	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	182	0	44,859	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03020	SLEEP LAB	0	13,876	0	0	76.00
76.01	03021	ONCOLOGY	346	3,029	138,832	0	76.01
76.02	03022	ECLIPSYS	0	0	0	0	76.02
76.03	03023	WOUND CARE	0	0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	1,447	864	111,084	0	90.00
91.00	09100	EMERGENCY	7,217	27,895	991,052	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		SUBTOTALS (SUM OF LINES 1-117)	113,439	683,621	7,773,849	-6,258,097	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	339	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,432	0	0	0	192.00
194.00	07950	MARKETING	735	0	0	0	194.00
194.01	07951	FOUNDATION	311	0	0	0	194.01
194.02	07952	CLINIC	0	0	0	0	194.02
194.03	07953	VACANT	686	0	0	0	194.03
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)	657,252	683,622	3,001,685		202.00
203.00		Unit cost multiplier (wkst. B, Part I)	5.620325	1.000001	0.386126		203.00
204.00		Cost to be allocated (per wkst. B, Part II)			4,911		204.00
205.00		Unit cost multiplier (wkst. B, Part II)			0.000632		205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151308

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

Worksheet B-1

Date/Time Prepared:  
11/22/2013 12:50 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (PATIENT DAYS)	CAFETERIA (HOURS)	
		7.00	8.00	9.00	10.00	11.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW 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	54,722				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,393	147,378			8.00
9.00	00900	HOUSEKEEPING	849	30,470	1,507		9.00
10.00	01000	DIETARY	2,310	1,896	1	2,505	10.00
11.00	01100	CAFETERIA	1,465	2,929	0	0	206,530
13.00	01300	NURSING ADMINISTRATION	1,688	0	19	0	4,740
15.00	01500	PHARMACY	1,299	0	51	0	8,561
16.00	01600	MEDICAL RECORDS & LIBRARY	2,035	0	7	0	9,119
17.00	01700	SOCIAL SERVICE	401	0	20	0	3,001
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	7,960	48,668	513	2,505	46,250
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	7,815	15,800	128	0	16,867
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,017	11,940	169	0	36,232
56.00	05600	RADIOISOTOPE	0	0	0	0	0
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
60.00	06000	LABORATORY	2,197	0	45	0	0
65.00	06500	RESPIRATORY THERAPY	2,444	0	105	0	17,505
66.00	06600	PHYSICAL THERAPY	5,154	7,705	158	0	14,218
67.00	06700	OCCUPATIONAL THERAPY	182	0	0	0	1,241
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
76.00	03020	SLEEP LAB	0	2,400	30	0	1,339
76.01	03021	ONCOLOGY	346	0	49	0	4,184
76.02	03022	ECLIPSYS	0	0	0	0	0
76.03	03023	WOUND CARE	0	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	1,447	4,830	0	0	7,664
91.00	09100	EMERGENCY	7,217	20,740	181	0	35,609
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		SUBTOTALS (SUM OF LINES 1-117)	51,219	147,378	1,476	2,505	206,530
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	339	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,432	0	0	0	0
194.00	07950	MARKETING	735	0	10	0	0
194.01	07951	FOUNDATION	311	0	21	0	0
194.02	07952	CLINIC	0	0	0	0	0
194.03	07953	VACANT	686	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers					
202.00		Cost to be allocated (per wkst. B, Part I)	1,528,881	87,374	764,188	186,526	511,708
203.00		Unit cost multiplier (wkst. B, Part I)	27.939056	0.592856	507.092236	74.461477	2.477645
204.00		Cost to be allocated (per wkst. B, Part II)	164,242	13,311	29,465	27,833	25,488
205.00		Unit cost multiplier (wkst. B, Part II)	3.001389	0.090319	19.552090	11.110978	0.123411

Cost Center Description		NURSING ADMINISTRATION  (DIRECT NRSING HRS)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE  (TIME SPENT)	
		13.00	15.00	16.00	17.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	00100					1.00
2.00	00200					2.00
4.00	00400					4.00
5.00	00500					5.00
7.00	00700					7.00
8.00	00800					8.00
9.00	00900					9.00
10.00	01000					10.00
11.00	01100					11.00
13.00	01300	192,256				13.00
15.00	01500	8,561	1,000			15.00
16.00	01600	0	0	49,324,572		16.00
17.00	01700	3,001	0	0	4,990	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000	48,374	0	2,706,501	4,840	30.00
31.00	03100	0	0	0	0	31.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	16,867	0	7,328,731	0	50.00
54.00	05400	36,231	0	15,495,063	0	54.00
56.00	05600	0	0	0	0	56.00
57.00	05700	0	0	0	0	57.00
58.00	05800	0	0	0	0	58.00
60.00	06000	0	0	8,379,421	0	60.00
65.00	06500	17,505	0	1,924,674	0	65.00
66.00	06600	14,218	0	1,943,241	0	66.00
67.00	06700	1,241	0	216,419	0	67.00
68.00	06800	0	0	115,021	0	68.00
69.00	06900	0	0	0	0	69.00
70.00	07000	0	0	0	0	70.00
71.00	07100	0	0	0	0	71.00
72.00	07200	0	0	0	0	72.00
73.00	07300	0	1,000	0	0	73.00
76.00	03020	1,339	0	491,587	0	76.00
76.01	03021	4,184	0	784,656	0	76.01
76.02	03022	0	0	0	0	76.02
76.03	03023	0	0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000	5,243	0	510,640	0	90.00
91.00	09100	35,492	0	9,428,618	150	91.00
92.00	09200					92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00		192,256	1,000	49,324,572	4,990	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00	19000	0	0	0	0	190.00
192.00	19200	0	0	0	0	192.00
194.00	07950	0	0	0	0	194.00
194.01	07951	0	0	0	0	194.01
194.02	07952	0	0	0	0	194.02
194.03	07953	0	0	0	0	194.03
200.00						200.00
201.00						201.00
202.00		454,907	3,439,711	355,540	252,934	202.00
203.00		2.366152	3,439.711000	0.007208	50.688176	203.00
204.00		29,329	145,269	26,219	10,586	204.00
205.00		0.152552	145.269000	0.000532	2.121443	205.00

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			Total Costs	
				Total Costs	RCE Disallowance	Total Costs		
		1.00	2.00	3.00	4.00	5.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	3,604,495		3,604,495	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	1,553,847		1,553,847	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,978,220		3,978,220	0	0	54.00
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
60.00	06000	LABORATORY	1,793,005		1,793,005	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,235,087	0	1,235,087	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,161,350	0	1,161,350	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	101,063	0	101,063	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	46,749	0	46,749	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	203,042		203,042	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	198,307		198,307	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,439,711		3,439,711	0	0	73.00
76.00	03020	SLEEP LAB	116,655		116,655	0	0	76.00
76.01	03021	ONCOLOGY	361,209		361,209	0	0	76.01
76.02	03022	ECLIPSYS	0		0	0	0	76.02
76.03	03023	WOUND CARE	0		0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	448,528		448,528	0	0	90.00
91.00	09100	EMERGENCY	3,900,526		3,900,526	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	600,708		600,708	0	0	92.00
200.00		Subtotal (see instructions)	22,742,502	0	22,742,502	0	0	200.00
201.00		Less Observation Beds	600,708		600,708	0	0	201.00
202.00		Total (see instructions)	22,141,794	0	22,141,794	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151308

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

Worksheet C  
Part I  
Date/Time Prepared:  
11/22/2013 12:50 pm

		Title XVIII			Hospital	Cost	
Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
					9.00	10.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	2,214,093		2,214,093		30.00
31.00	03100	INTENSIVE CARE UNIT	0		0		31.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	931,984	6,396,747	7,328,731	0.212021	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,240,893	14,254,170	15,495,063	0.256741	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	1,219,338	7,160,083	8,379,421	0.213977	60.00
65.00	06500	RESPIRATORY THERAPY	1,131,912	792,762	1,924,674	0.641712	65.00
66.00	06600	PHYSICAL THERAPY	219,190	1,724,051	1,943,241	0.597636	66.00
67.00	06700	OCCUPATIONAL THERAPY	78,877	137,542	216,419	0.466978	67.00
68.00	06800	SPEECH PATHOLOGY	49,882	65,139	115,021	0.406439	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	700,432	755,841	1,456,273	0.139426	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	160,619	364,134	524,753	0.377905	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,693,325	6,526,673	8,219,998	0.418456	73.00
76.00	03020	SLEEP LAB	0	491,587	491,587	0.237303	76.00
76.01	03021	ONCOLOGY	14,823	769,833	784,656	0.460341	76.01
76.02	03022	ECLIPSYS	0	0	0	0.000000	76.02
76.03	03023	WOUND CARE	0	0	0	0.000000	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	7,519	503,121	510,640	0.878364	90.00
91.00	09100	EMERGENCY	318,571	9,110,578	9,429,149	0.413667	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	23,419	468,989	492,408	1.219940	92.00
200.00		Subtotal (see instructions)	10,004,877	49,521,250	59,526,127		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	10,004,877	49,521,250	59,526,127		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151308

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

Worksheet C  
Part I  
Date/Time Prepared:  
11/22/2013 12:50 pm

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	Cost
		11.00			
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.000000		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
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
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03020	SLEEP LAB	0.000000		76.00
76.01	03021	ONCOLOGY	0.000000		76.01
76.02	03022	ECLIPSYS	0.000000		76.02
76.03	03023	WOUND CARE	0.000000		76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
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: 151308

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

Worksheet C  
Part I  
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11/22/2013 12:50 pm

		Title XIX		Hospital		Cost	
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Disallowance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS	3,604,495		3,604,495	0	0	30.00
31.00	03100 INTENSIVE CARE UNIT	0		0	0	0	31.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	1,553,847		1,553,847	0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	3,978,220		3,978,220	0	0	54.00
56.00	05600 RADIOISOTOPE	0		0	0	0	56.00
57.00	05700 CT SCAN	0		0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
60.00	06000 LABORATORY	1,793,005		1,793,005	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	1,235,087	0	1,235,087	0	0	65.00
66.00	06600 PHYSICAL THERAPY	1,161,350	0	1,161,350	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	101,063	0	101,063	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	46,749	0	46,749	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0		0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	203,042		203,042	0	0	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	198,307		198,307	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	3,439,711		3,439,711	0	0	73.00
76.00	03020 SLEEP LAB	116,655		116,655	0	0	76.00
76.01	03021 ONCOLOGY	361,209		361,209	0	0	76.01
76.02	03022 ECLIPSYS	0		0	0	0	76.02
76.03	03023 WOUND CARE	0		0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	448,528		448,528	0	0	90.00
91.00	09100 EMERGENCY	3,900,526		3,900,526	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	600,708		600,708	0	0	92.00
200.00	Subtotal (see instructions)	22,742,502	0	22,742,502	0	0	200.00
201.00	Less Observation Beds	600,708		600,708			201.00
202.00	Total (see instructions)	22,141,794	0	22,141,794	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151308

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

Worksheet C  
Part I  
Date/Time Prepared:  
11/22/2013 12:50 pm

		Title XIX			Hospital	Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				
	9.00	10.00					
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	2,214,093		2,214,093		30.00
31.00	03100	INTENSIVE CARE UNIT	0		0		31.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	931,984	6,396,747	7,328,731	0.212021	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,240,893	14,254,170	15,495,063	0.256741	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	1,219,338	7,160,083	8,379,421	0.213977	60.00
65.00	06500	RESPIRATORY THERAPY	1,131,912	792,762	1,924,674	0.641712	65.00
66.00	06600	PHYSICAL THERAPY	219,190	1,724,051	1,943,241	0.597636	66.00
67.00	06700	OCCUPATIONAL THERAPY	78,877	137,542	216,419	0.466978	67.00
68.00	06800	SPEECH PATHOLOGY	49,882	65,139	115,021	0.406439	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	700,432	755,841	1,456,273	0.139426	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	160,619	364,134	524,753	0.377905	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,693,325	6,526,673	8,219,998	0.418456	73.00
76.00	03020	SLEEP LAB	0	491,587	491,587	0.237303	76.00
76.01	03021	ONCOLOGY	14,823	769,833	784,656	0.460341	76.01
76.02	03022	ECLIPSYS	0	0	0	0.000000	76.02
76.03	03023	WOUND CARE	0	0	0	0.000000	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	7,519	503,121	510,640	0.878364	90.00
91.00	09100	EMERGENCY	318,571	9,110,578	9,429,149	0.413667	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	23,419	468,989	492,408	1.219940	92.00
200.00		Subtotal (see instructions)	10,004,877	49,521,250	59,526,127		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	10,004,877	49,521,250	59,526,127		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151308

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

Worksheet C  
Part I  
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11/22/2013 12:50 pm

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0.000000			50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
56.00	05600 RADIOISOTOPE	0.000000			56.00
57.00	05700 CT SCAN	0.000000			57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000			58.00
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
67.00	06700 OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800 SPEECH PATHOLOGY	0.000000			68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.00	03020 SLEEP LAB	0.000000			76.00
76.01	03021 ONCOLOGY	0.000000			76.01
76.02	03022 ECLIPSYS	0.000000			76.02
76.03	03023 WOUND CARE	0.000000			76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000 CLINIC	0.000000			90.00
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
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: 151308

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

Worksheet C Part II Date/Time Prepared: 11/22/2013 12:50 pm

Cost Center Description		Title XIX			Hospital Cost			
		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		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	1,553,847	226,636	1,327,211	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,978,220	444,043	3,534,177	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	1,793,005	68,532	1,724,473	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,235,087	70,073	1,165,014	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,161,350	78,137	1,083,213	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	101,063	4,427	96,636	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	46,749	1,294	45,455	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	203,042	5,451	197,591	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	198,307	5,324	192,983	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,439,711	145,269	3,294,442	0	0	73.00
76.00	03020	SLEEP LAB	116,655	17,727	98,928	0	0	76.00
76.01	03021	ONCOLOGY	361,209	16,703	344,506	0	0	76.01
76.02	03022	ECLIPSYS	0	0	0	0	0	76.02
76.03	03023	WOUND CARE	0	0	0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	448,528	25,801	422,727	0	0	90.00
91.00	09100	EMERGENCY	3,900,526	201,152	3,699,374	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	600,708	0	600,708	0	0	92.00
200.00		Subtotal (sum of lines 50 thru 199)	19,138,007	1,310,569	17,827,438	0	0	200.00
201.00		Less Observation Beds	600,708	0	600,708	0	0	201.00
202.00		Total (line 200 minus line 201)	18,537,299	1,310,569	17,226,730	0	0	202.00

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

Provider CCN: 151308

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

Worksheet C Part II Date/Time Prepared: 11/22/2013 12:50 pm

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)	Hospital Cost
		6.00	7.00	8.00	
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	1,553,847	7,328,731	0.212021	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	3,978,220	15,495,063	0.256741	54.00
56.00	05600 RADIOISOTOPE	0	0	0.000000	56.00
57.00	05700 CT SCAN	0	0	0.000000	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	58.00
60.00	06000 LABORATORY	1,793,005	8,379,421	0.213977	60.00
65.00	06500 RESPIRATORY THERAPY	1,235,087	1,924,674	0.641712	65.00
66.00	06600 PHYSICAL THERAPY	1,161,350	1,943,241	0.597636	66.00
67.00	06700 OCCUPATIONAL THERAPY	101,063	216,419	0.466978	67.00
68.00	06800 SPEECH PATHOLOGY	46,749	115,021	0.406439	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0.000000	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0.000000	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	203,042	1,456,273	0.139426	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	198,307	524,753	0.377905	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	3,439,711	8,219,998	0.418456	73.00
76.00	03020 SLEEP LAB	116,655	491,587	0.237303	76.00
76.01	03021 ONCOLOGY	361,209	784,656	0.460341	76.01
76.02	03022 ECLIPSYS	0	0	0.000000	76.02
76.03	03023 WOUND CARE	0	0	0.000000	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000 CLINIC	448,528	510,640	0.878364	90.00
91.00	09100 EMERGENCY	3,900,526	9,429,149	0.413667	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	600,708	492,408	1.219940	92.00
200.00	Subtotal (sum of lines 50 thru 199)	19,138,007	57,312,034		200.00
201.00	Less Observation Beds	600,708	0		201.00
202.00	Total (line 200 minus line 201)	18,537,299	57,312,034		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 151308	Period: From 07/01/2012 To 06/30/2013	Worksheet D Part II Date/Time Prepared: 11/22/2013 12:50 pm
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Cost Center Description		Capital Related Cost (from wkst. B, Part II, col. 26)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	226,636	7,328,731	0.030924	395,905	12,243	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	444,043	15,495,063	0.028657	315,381	9,038	54.00
56.00	05600 RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700 CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
60.00	06000 LABORATORY	68,532	8,379,421	0.008179	546,108	4,467	60.00
65.00	06500 RESPIRATORY THERAPY	70,073	1,924,674	0.036408	652,789	23,767	65.00
66.00	06600 PHYSICAL THERAPY	78,137	1,943,241	0.040210	96,618	3,885	66.00
67.00	06700 OCCUPATIONAL THERAPY	4,427	216,419	0.020456	26,548	543	67.00
68.00	06800 SPEECH PATHOLOGY	1,294	115,021	0.011250	20,704	233	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	5,451	1,456,273	0.003743	295,130	1,105	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	5,324	524,753	0.010146	35,555	361	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	145,269	8,219,998	0.017673	800,406	14,146	73.00
76.00	03020 SLEEP LAB	17,727	491,587	0.036061	0	0	76.00
76.01	03021 ONCOLOGY	16,703	784,656	0.021287	1,733	37	76.01
76.02	03022 ECLIPSYS	0	0	0.000000	0	0	76.02
76.03	03023 WOUND CARE	0	0	0.000000	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	25,801	510,640	0.050527	3,319	168	90.00
91.00	09100 EMERGENCY	201,152	9,429,149	0.021333	3,504	75	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	492,408	0.000000	0	0	92.00
200.00	Total (lines 50-199)	1,310,569	57,312,034		3,193,700	70,068	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151308

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

Worksheet D  
Part IV  
Date/Time Prepared:  
11/22/2013 12:50 pm

Cost Center Description		Title XVIII				Hospital	Cost
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03020	SLEEP LAB	0	0	0	0	76.00
76.01	03021	ONCOLOGY	0	0	0	0	76.01
76.02	03022	ECLIPSYS	0	0	0	0	76.02
76.03	03023	WOUND CARE	0	0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151308

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

Worksheet D  
Part IV  
Date/Time Prepared:  
11/22/2013 12:50 pm

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Cost
		6.00	7.00	8.00	9.00	10.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	7,328,731	0.000000	0.000000	395,905 50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	15,495,063	0.000000	0.000000	315,381 54.00
56.00	05600	RADIOISOTOPE	0	0	0.000000	0.000000	0 56.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0 58.00
60.00	06000	LABORATORY	0	8,379,421	0.000000	0.000000	546,108 60.00
65.00	06500	RESPIRATORY THERAPY	0	1,924,674	0.000000	0.000000	652,789 65.00
66.00	06600	PHYSICAL THERAPY	0	1,943,241	0.000000	0.000000	96,618 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	216,419	0.000000	0.000000	26,548 67.00
68.00	06800	SPEECH PATHOLOGY	0	115,021	0.000000	0.000000	20,704 68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,456,273	0.000000	0.000000	295,130 71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	524,753	0.000000	0.000000	35,555 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	8,219,998	0.000000	0.000000	800,406 73.00
76.00	03020	SLEEP LAB	0	491,587	0.000000	0.000000	0 76.00
76.01	03021	ONCOLOGY	0	784,656	0.000000	0.000000	1,733 76.01
76.02	03022	ECLIPSYS	0	0	0.000000	0.000000	0 76.02
76.03	03023	WOUND CARE	0	0	0.000000	0.000000	0 76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	510,640	0.000000	0.000000	3,319 90.00
91.00	09100	EMERGENCY	0	9,429,149	0.000000	0.000000	3,504 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	492,408	0.000000	0.000000	0 92.00
200.00		Total (lines 50-199)	0	57,312,034			3,193,700 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151308

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

Worksheet D  
Part IV  
Date/Time Prepared:  
11/22/2013 12:50 pm

Cost Center Description		Title XVIII			Hospital			
		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School Cost		
		11.00	12.00	13.00	21.00	22.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
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
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	SLEEP LAB	0	0	0	0	0	76.00
76.01	03021	ONCOLOGY	0	0	0	0	0	76.01
76.02	03022	ECLIPSYS	0	0	0	0	0	76.02
76.03	03023	WOUND CARE	0	0	0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
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: 151308

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

Worksheet D  
Part IV  
Date/Time Prepared:  
11/22/2013 12:50 pm

Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost		
		23.00	24.00		
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0	0		50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00	05600 RADIOISOTOPE	0	0		56.00
57.00	05700 CT SCAN	0	0		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
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
67.00	06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800 SPEECH PATHOLOGY	0	0		68.00
69.00	06900 ELECTROCARDIOLOGY	0	0		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03020 SLEEP LAB	0	0		76.00
76.01	03021 ONCOLOGY	0	0		76.01
76.02	03022 ECLIPSYS	0	0		76.02
76.03	03023 WOUND CARE	0	0		76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000 CLINIC	0	0		90.00
91.00	09100 EMERGENCY	0	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00	Total (lines 50-199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151308	Period: From 07/01/2012 To 06/30/2013	Worksheet D Part V Date/Time Prepared: 11/22/2013 12:50 pm
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		Title XVIII		Hospital	Cost		
Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
	1.00	2.00	3.00	4.00	5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0.212021	0	2,334,255	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.256741	0	4,312,868	2,319	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	58.00
60.00	06000	LABORATORY	0.213977	0	2,455,451	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.641712	0	987,353	0	65.00
66.00	06600	PHYSICAL THERAPY	0.597636	0	635,121	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.466978	0	30,805	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.406439	0	22,154	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.139426	0	391,992	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.377905	0	113,415	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.418456	0	2,451,701	3,977	73.00
76.00	03020	SLEEP LAB	0.237303	0	0	0	76.00
76.01	03021	ONCOLOGY	0.460341	0	182,462	0	76.01
76.02	03022	ECLIPSYS	0.000000	0	0	0	76.02
76.03	03023	WOUND CARE	0.000000	0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0.878364	0	285,830	0	90.00
91.00	09100	EMERGENCY	0.413667	0	2,319,938	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.219940	0	235,363	0	92.00
200.00		Subtotal (see instructions)		0	16,758,708	6,296	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00		Net Charges (line 200 +/- line 201)		0	16,758,708	6,296	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151308

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

Worksheet D  
Part V  
Date/Time Prepared:  
11/22/2013 12:50 pm

		Title XVIII		Hospital	Cost
Cost Center Description	Costs				
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
	6.00	7.00			
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	494,911	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,107,290	595	54.00
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
60.00	06000	LABORATORY	525,410	0	60.00
65.00	06500	RESPIRATORY THERAPY	633,596	0	65.00
66.00	06600	PHYSICAL THERAPY	379,571	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	14,385	0	67.00
68.00	06800	SPEECH PATHOLOGY	9,004	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	54,654	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	42,860	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,025,929	1,664	73.00
76.00	03020	SLEEP LAB	0	0	76.00
76.01	03021	ONCOLOGY	83,995	0	76.01
76.02	03022	ECLIPSYS	0	0	76.02
76.03	03023	WOUND CARE	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	251,063	0	90.00
91.00	09100	EMERGENCY	959,682	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	287,129	0	92.00
200.00		Subtotal (see instructions)	5,869,479	2,259	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	5,869,479	2,259	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151308

Period: From 07/01/2012

Worksheet D

Component CCN: 152308

To 06/30/2013

Part V  
Date/Time Prepared: 11/22/2013 12:50 pm

Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
		1.00	2.00	3.00	4.00	5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0.212021	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.256741	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.213977	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.641712	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.597636	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.466978	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.406439	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.139426	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.377905	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.418456	0	0	0	0	73.00
76.00	03020	SLEEP LAB	0.237303	0	0	0	0	76.00
76.01	03021	ONCOLOGY	0.460341	0	0	0	0	76.01
76.02	03022	ECLIPSYS	0.000000	0	0	0	0	76.02
76.03	03023	WOUND CARE	0.000000	0	0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0.878364	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.413667	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.219940	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	0	201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151308

Period: From 07/01/2012

Worksheet D

Component CCN: 152308

To 06/30/2013

Part V

Date/Time Prepared: 11/22/2013 12:50 pm

		Title XVIII		Swing Beds - SNF	Cost
Cost Center Description	Costs				
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
	6.00	7.00			
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
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
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
76.00	03020	SLEEP LAB	0	0	76.00
76.01	03021	ONCOLOGY	0	0	76.01
76.02	03022	ECLIPSYS	0	0	76.02
76.03	03023	WOUND CARE	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0	0	201.00
202.00		Net Charges (line 200 +/- line 201)	0	0	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 151308

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

Worksheet D  
Part I  
Date/Time Prepared:  
11/22/2013 12:50 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		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	ADULTS & PEDIATRICS	316,638	48,113	268,525	2,478	108.36	30.00	
31.00	INTENSIVE CARE UNIT	0		0	0	0.00	31.00	
200.00	Total (lines 30-199)	316,638		268,525	2,478		200.00	
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)					
		6.00	7.00					
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	ADULTS & PEDIATRICS	91	9,861					30.00
31.00	INTENSIVE CARE UNIT	0	0					31.00
200.00	Total (lines 30-199)	91	9,861					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 151308

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

Worksheet D  
Part II  
Date/Time Prepared:  
11/22/2013 12:50 pm

Cost Center Description		Title XIX			Hospital	Cost		
		Capital Related Cost (from wkst. B, Part II, col. 26)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	226,636	7,328,731	0.030924	132,396	4,094	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	444,043	15,495,063	0.028657	140,740	4,033	54.00
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	68,532	8,379,421	0.008179	105,485	863	60.00
65.00	06500	RESPIRATORY THERAPY	70,073	1,924,674	0.036408	74,745	2,721	65.00
66.00	06600	PHYSICAL THERAPY	78,137	1,943,241	0.040210	3,842	154	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,427	216,419	0.020456	1,218	25	67.00
68.00	06800	SPEECH PATHOLOGY	1,294	115,021	0.011250	742	8	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,451	1,456,273	0.003743	68,121	255	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	5,324	524,753	0.010146	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	145,269	8,219,998	0.017673	125,079	2,211	73.00
76.00	03020	SLEEP LAB	17,727	491,587	0.036061	0	0	76.00
76.01	03021	ONCOLOGY	16,703	784,656	0.021287	799	17	76.01
76.02	03022	ECLIPSYS	0	0	0.000000	0	0	76.02
76.03	03023	WOUND CARE	0	0	0.000000	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	25,801	510,640	0.050527	0	0	90.00
91.00	09100	EMERGENCY	201,152	9,429,149	0.021333	99,967	2,133	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	492,408	0.000000	4,099	0	92.00
200.00		Total (lines 50-199)	1,310,569	57,312,034		757,233	16,514	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151308

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

Worksheet D  
Part III  
Date/Time Prepared:  
11/22/2013 12:50 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		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>									
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0		
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0		
200.00		Total (lines 30-199)	0	0	0	0	0		
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. Nursing School		
			6.00	7.00	8.00	9.00	11.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>									
30.00	03000	ADULTS & PEDIATRICS	2,478	0.00	91	0	0		
31.00	03100	INTENSIVE CARE UNIT	0	0.00	0	0	0		
200.00		Total (lines 30-199)	2,478		91	0	0		
Cost Center Description			PSA Adj. Allied Health Cost	PSA Adj. All Other Medical Education Cost					
			12.00	13.00					
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>									
30.00	03000	ADULTS & PEDIATRICS	0	0					
31.00	03100	INTENSIVE CARE UNIT	0	0					
200.00		Total (lines 30-199)	0	0					

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151308

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

Worksheet D  
Part IV  
Date/Time Prepared:  
11/22/2013 12:50 pm

Cost Center Description	Title XIX				Hospital	Cost
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
	1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	0	0	0	0	0	50.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00 05600 RADIOISOTOPE	0	0	0	0	0	56.00
57.00 05700 CT SCAN	0	0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
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
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00 03020 SLEEP LAB	0	0	0	0	0	76.00
76.01 03021 ONCOLOGY	0	0	0	0	0	76.01
76.02 03022 ECLIPSYS	0	0	0	0	0	76.02
76.03 03023 WOUND CARE	0	0	0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000 CLINIC	0	0	0	0	0	90.00
91.00 09100 EMERGENCY	0	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
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: 151308

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

Worksheet D Part IV Date/Time Prepared: 11/22/2013 12:50 pm

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	Cost
		6.00	7.00	8.00	9.00	10.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	7,328,731	0.000000	0.000000	132,396	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	15,495,063	0.000000	0.000000	140,740	54.00
56.00	05600 RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
57.00	05700 CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
60.00	06000 LABORATORY	0	8,379,421	0.000000	0.000000	105,485	60.00
65.00	06500 RESPIRATORY THERAPY	0	1,924,674	0.000000	0.000000	74,745	65.00
66.00	06600 PHYSICAL THERAPY	0	1,943,241	0.000000	0.000000	3,842	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	216,419	0.000000	0.000000	1,218	67.00
68.00	06800 SPEECH PATHOLOGY	0	115,021	0.000000	0.000000	742	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,456,273	0.000000	0.000000	68,121	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	524,753	0.000000	0.000000	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	8,219,998	0.000000	0.000000	125,079	73.00
76.00	03020 SLEEP LAB	0	491,587	0.000000	0.000000	0	76.00
76.01	03021 ONCOLOGY	0	784,656	0.000000	0.000000	799	76.01
76.02	03022 ECLIPSYS	0	0	0.000000	0.000000	0	76.02
76.03	03023 WOUND CARE	0	0	0.000000	0.000000	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0	510,640	0.000000	0.000000	0	90.00
91.00	09100 EMERGENCY	0	9,429,149	0.000000	0.000000	99,967	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	492,408	0.000000	0.000000	4,099	92.00
200.00	Total (lines 50-199)	0	57,312,034			757,233	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151308

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

Worksheet D  
Part IV  
Date/Time Prepared:  
11/22/2013 12:50 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)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03020	SLEEP LAB	0	0	0	0	76.00
76.01	03021	ONCOLOGY	0	0	0	0	76.01
76.02	03022	ECLIPSYS	0	0	0	0	76.02
76.03	03023	WOUND CARE	0	0	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151308

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

Worksheet D  
Part IV  
Date/Time Prepared:  
11/22/2013 12:50 pm

Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	Title XIX	Hospital	Cost
		23.00	24.00			
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	0	0			50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0			54.00
56.00	05600 RADIOISOTOPE	0	0			56.00
57.00	05700 CT SCAN	0	0			57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0			58.00
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
67.00	06700 OCCUPATIONAL THERAPY	0	0			67.00
68.00	06800 SPEECH PATHOLOGY	0	0			68.00
69.00	06900 ELECTROCARDIOLOGY	0	0			69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0			70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0			73.00
76.00	03020 SLEEP LAB	0	0			76.00
76.01	03021 ONCOLOGY	0	0			76.01
76.02	03022 ECLIPSYS	0	0			76.02
76.03	03023 WOUND CARE	0	0			76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000 CLINIC	0	0			90.00
91.00	09100 EMERGENCY	0	0			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0			92.00
200.00	Total (lines 50-199)	0	0			200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151308	Period: From 07/01/2012 To 06/30/2013	Worksheet D-1 Date/Time Prepared: 11/22/2013 12:50 pm
Cost Center Description		Title XVIII	Hospital	Cost
				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			2,984 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			2,478 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)			1,990 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			222 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)			222 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			31 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)			31 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			1,148 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)			222 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)			222 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0 14.00
15.00	Total nursery days (title V or XIX only)			0 15.00
16.00	Nursery days (title V or XIX only)			0 16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		123.32	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		123.32	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,604,495	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)		3,823	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)		3,823	25.00
26.00	Total swing-bed cost (see instructions)		554,188	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		3,050,307	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		3,050,307	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,230.95	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,413,131	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,413,131	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151308

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

Worksheet D-1

Date/Time Prepared:  
11/22/2013 12:50 pm

Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
<b>Intensive Care Type Inpatient Hospital Units</b>							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					1,173,905	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,587,036	49.00
<b>PASS THROUGH COST ADJUSTMENTS</b>							
50.00	Pass through costs applicable to Program inpatient routine services (from wkst. D, sum of Parts I and III)					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
<b>TARGET AMOUNT AND LIMIT COMPUTATION</b>							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
<b>PROGRAM INPATIENT ROUTINE SWING BED COST</b>							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					273,271	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					273,271	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					546,542	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
<b>PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY</b>							
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
<b>PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>							
87.00	Total observation bed days (see instructions)					488	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,230.96	88.00
89.00	observation bed cost (line 87 x line 88) (see instructions)					600,708	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 151308	Period: From 07/01/2012 To 06/30/2013	Worksheet D-1 Date/Time Prepared: 11/22/2013 12:50 pm
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Cost Center Description	Title XVIII			Hospital	
	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)
	1.00	2.00	3.00	4.00	5.00
<b>COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>					
90.00 Capital-related cost	0	0	0.000000	0	0 90.00
91.00 Nursing School cost	0	0	0.000000	0	0 91.00
92.00 Allied health cost	0	0	0.000000	0	0 92.00
93.00 All other Medical Education	0	0	0.000000	0	0 93.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151308

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

Worksheet D-1

Date/Time Prepared:  
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Title XIX		Hospital	Cost
Cost Center Description			1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>			
<b>INPATIENT DAYS</b>			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,984 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,478 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)		1,990 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		229 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)		215 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		31 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)		31 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		91 9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0 10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0 14.00
15.00	Total nursery days (title V or XIX only)		0 15.00
16.00	Nursery days (title V or XIX only)		0 16.00
<b>SWING BED ADJUSTMENT</b>			
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,604,495	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)	547,705	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,056,790	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>			
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,056,790	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>			
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>			
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,233.57	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	112,255	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)	112,255	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151308

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

Worksheet D-1

Date/Time Prepared:  
11/22/2013 12:50 pm

Cost Center Description	Title XIX			Hospital	Cost
	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
<b>Intensive Care Type Inpatient Hospital Units</b>					
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	43.00
44.00 CORONARY CARE UNIT					44.00
45.00 BURN INTENSIVE CARE UNIT					45.00
46.00 SURGICAL INTENSIVE CARE UNIT					46.00
47.00 OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description					1.00
48.00 Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					246,468 48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					358,723 49.00
<b>PASS THROUGH COST ADJUSTMENTS</b>					
50.00 Pass through costs applicable to Program inpatient routine services (from wkst. D, sum of Parts I and III)					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
<b>TARGET AMOUNT AND LIMIT COMPUTATION</b>					
54.00 Program discharges					0 54.00
55.00 Target amount per discharge					0.00 55.00
56.00 Target amount (line 54 x line 55)					0 56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0 57.00
58.00 Bonus payment (see instructions)					0 58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00 59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00 60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0 61.00
62.00 Relief payment (see instructions)					0 62.00
63.00 Allowable inpatient cost plus incentive payment (see instructions)					0 63.00
<b>PROGRAM INPATIENT ROUTINE SWING BED COST</b>					
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0 64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0 65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0 66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0 67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0 68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0 69.00
<b>PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY</b>					
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)					70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00 Program routine service cost (line 9 x line 71)					72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00 Program capital-related costs (line 9 x line 76)					77.00
78.00 Inpatient routine service cost (line 74 minus line 77)					78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00 Inpatient routine service cost per diem limitation					81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00 Reasonable inpatient routine service costs (see instructions)					83.00
84.00 Program inpatient ancillary services (see instructions)					84.00
85.00 Utilization review - physician compensation (see instructions)					85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
<b>PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>					
87.00 Total observation bed days (see instructions)					488 87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,233.57 88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					601,982 89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151308

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

Worksheet D-1

Date/Time Prepared:  
11/22/2013 12:50 pm

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151308	Period: From 07/01/2012 To 06/30/2013	Worksheet D-3	
		Title XVIII	Hospital	Date/Time Prepared: 11/22/2013 12:50 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2) Cost	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		1,144,911	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.212021	395,905	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.256741	315,381	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	56.00
57.00	05700	CT SCAN	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	58.00
60.00	06000	LABORATORY	0.213977	546,108	60.00
65.00	06500	RESPIRATORY THERAPY	0.641712	652,789	65.00
66.00	06600	PHYSICAL THERAPY	0.597636	96,618	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.466978	26,548	67.00
68.00	06800	SPEECH PATHOLOGY	0.406439	20,704	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.139426	295,130	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.377905	35,555	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.418456	800,406	73.00
76.00	03020	SLEEP LAB	0.237303	0	76.00
76.01	03021	ONCOLOGY	0.460341	1,733	76.01
76.02	03022	ECLIPSYS	0.000000	0	76.02
76.03	03023	WOUND CARE	0.000000	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0.878364	3,319	90.00
91.00	09100	EMERGENCY	0.413667	3,504	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.219940	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		3,193,700	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net charges (line 200 minus line 201)		3,193,700	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 151308

Period: From 07/01/2012

Worksheet D-3

Component CCN: 152308

To 06/30/2013

Date/Time Prepared: 11/22/2013 12:50 pm

Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	Cost
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0.212021	5	1	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.256741	46,934	12,050	54.00
56.00	05600 RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700 CT SCAN	0.000000	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
60.00	06000 LABORATORY	0.213977	97,114	20,780	60.00
65.00	06500 RESPIRATORY THERAPY	0.641712	159,217	102,171	65.00
66.00	06600 PHYSICAL THERAPY	0.597636	65,647	39,233	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.466978	30,697	14,335	67.00
68.00	06800 SPEECH PATHOLOGY	0.406439	15,021	6,105	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.139426	81,361	11,344	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.377905	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.418456	141,939	59,395	73.00
76.00	03020 SLEEP LAB	0.237303	0	0	76.00
76.01	03021 ONCOLOGY	0.460341	1,373	632	76.01
76.02	03022 ECLIPSYS	0.000000	0	0	76.02
76.03	03023 WOUND CARE	0.000000	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000 CLINIC	0.878364	4,200	3,689	90.00
91.00	09100 EMERGENCY	0.413667	27	11	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.219940	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		643,535	269,746	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)		643,535		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 151308

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

Worksheet D-3

Date/Time Prepared:  
11/22/2013 12:50 pm

Cost Center Description		Ratio of Cost To Charges	Hospital Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS		146,948		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0.212021	132,396	28,071	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.256741	140,740	36,134	54.00
56.00	05600 RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700 CT SCAN	0.000000	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
60.00	06000 LABORATORY	0.213977	105,485	22,571	60.00
65.00	06500 RESPIRATORY THERAPY	0.641712	74,745	47,965	65.00
66.00	06600 PHYSICAL THERAPY	0.597636	3,842	2,296	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.466978	1,218	569	67.00
68.00	06800 SPEECH PATHOLOGY	0.406439	742	302	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.139426	68,121	9,498	71.00
72.00	07200 IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.377905	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.418456	125,079	52,340	73.00
76.00	03020 SLEEP LAB	0.237303	0	0	76.00
76.01	03021 ONCOLOGY	0.460341	799	368	76.01
76.02	03022 ECLIPSYS	0.000000	0	0	76.02
76.03	03023 WOUND CARE	0.000000	0	0	76.03
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000 CLINIC	0.878364	0	0	90.00
91.00	09100 EMERGENCY	0.413667	99,967	41,353	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.219940	4,099	5,001	92.00
200.00	Total (sum of lines 50-94 and 96-98)		757,233	246,468	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)		757,233		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151308	Period: From 07/01/2012 To 06/30/2013	Worksheet E Part B Date/Time Prepared: 11/22/2013 12:50 pm
		Title XVIII	Hospital	Cost
				1.00
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		5,871,738	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	PPS payments		0	3.00
4.00	Outlier payment (see instructions)		0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from worksheet D, Part IV, column 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		5,871,738	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from worksheet D-4, Part III, line 69, col. 4)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
<b>Customary charges</b>				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)		5,930,455	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		0	24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance (for CAH, see instructions)		34,426	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		2,851,722	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)		3,044,307	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)		3,044,307	30.00
31.00	Primary payer payments		173	31.00
32.00	Subtotal (line 30 minus line 31)		3,044,134	32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from worksheet I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		612,366	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		612,366	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		307,658	36.00
37.00	Subtotal (see instructions)		3,656,500	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00			0	39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		3,656,500	40.00
40.01	Sequestration adjustment (see instructions)		18,283	40.01
41.00	Interim payments		3,156,404	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		481,813	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		0	44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00
				Overrides
				1.00
<b>WORKSHEET OVERRIDE VALUES</b>				
112.00	override of Ancillary service charges (line 12)		0	112.00

		Title XVIII		Hospital	Cost	
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,260,070		3,156,404	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
<b>Program to Provider</b>						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
<b>Provider to Program</b>						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to wkst. E or wkst. E-3, line and column as appropriate)		2,260,070		3,156,404	4.00
<b>TO BE COMPLETED BY CONTRACTOR</b>						
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
<b>Program to Provider</b>						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
<b>Provider to Program</b>						
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		85,876		500,096	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,345,946		3,656,500	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151308  
Component CCN: 152308

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
11/22/2013 12:50 pm

		Title XVIII		Swing Beds - SNF		Cost	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		811,088		0		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
<b>Program to Provider</b>							
3.01	ADJUSTMENTS TO PROVIDER		0		0		3.01
3.02			0		0		3.02
3.03			0		0		3.03
3.04			0		0		3.04
3.05			0		0		3.05
<b>Provider to Program</b>							
3.50	ADJUSTMENTS TO PROGRAM		0		0		3.50
3.51			0		0		3.51
3.52			0		0		3.52
3.53			0		0		3.53
3.54			0		0		3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0		3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to wkst. E or wkst. E-3, line and column as appropriate)		811,088		0		4.00
<b>TO BE COMPLETED BY CONTRACTOR</b>							
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
<b>Program to Provider</b>							
5.01	TENTATIVE TO PROVIDER		0		0		5.01
5.02			0		0		5.02
5.03			0		0		5.03
<b>Provider to Program</b>							
5.50	TENTATIVE TO PROGRAM		0		0		5.50
5.51			0		0		5.51
5.52			0		0		5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0		5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)						6.00
6.01	SETTLEMENT TO PROVIDER		5,820		0		6.01
6.02	SETTLEMENT TO PROGRAM		0		0		6.02
7.00	Total Medicare program liability (see instructions)		816,908		0		7.00
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 151308

Period:

Worksheet E-2

Component CCN: 152308

From 07/01/2012

Date/Time Prepared:

To 06/30/2013

11/22/2013 12:50 pm

		Swing Beds - SNF		
		Cost		
		Part A	Part B	
		1.00	2.00	
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>				
1.00	Inpatient routine services - swing bed-SNF (see instructions)	552,007	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from wkst. D-3, column 3, line 200 for Part A, and sum of wkst. D, Part V, columns 5 and 7, line 202 for Part B) (For CAH, see instructions)	272,443	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	444	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	824,450	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	824,450	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	824,450	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	7,542	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	816,908	0	15.00
16.00	Allowable bad debts (see instructions)	0	0	16.00
17.00	Adjusted reimbursable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	816,908	0	19.00
19.01	Sequestration adjustment (see instructions)	4,085	0	19.01
20.00	Interim payments	811,088	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program line 19 minus lines 19.01, 20 and 21	1,735	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151308	Period: From 07/01/2012 To 06/30/2013	Worksheet E-3 Part V Date/Time Prepared: 11/22/2013 12:50 pm
		Title XVIII	Hospital	Cost
				1.00
<b>PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)</b>				
1.00	Inpatient services		2,587,036	1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction)		0	2.00
3.00	Organ acquisition		0	3.00
4.00	Subtotal (sum of lines 1 thru 3)		2,587,036	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		2,612,906	6.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
7.00	Routine service charges		0	7.00
8.00	Ancillary service charges		0	8.00
9.00	Organ acquisition charges, net of revenue		0	9.00
10.00	Total reasonable charges		0	10.00
<b>Customary charges</b>				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)		0.000000	13.00
14.00	Total customary charges (see instructions)		0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)		0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)		0	16.00
17.00	Cost of teaching physicians (from worksheet D-5, Part II, column 3, line 20) (see instructions)		0	17.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
18.00	Direct graduate medical education payments (from worksheet E-4, line 49)		0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)		2,612,906	19.00
20.00	Deductibles (exclude professional component)		288,724	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20)		2,324,182	22.00
23.00	Coinsurance		888	23.00
24.00	Subtotal (line 22 minus line 23)		2,323,294	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		22,652	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		22,652	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		3,628	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		2,345,946	28.00
29.00			0	29.00
29.99	Recovery of Accelerated Depreciation		0	29.99
30.00	Subtotal (line 28, plus or minus lines 29)		2,345,946	30.00
30.01	Sequestration adjustment (see instructions)		11,730	30.01
31.00	Interim payments		2,260,070	31.00
32.00	Tentative settlement (for contractor use only)		0	32.00
33.00	Balance due provider/program line 30 minus lines 30.01, 31, and 32		74,146	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151308	Period: From 07/01/2012 To 06/30/2013	Worksheet E-3 Part VII Date/Time Prepared: 11/22/2013 12:50 pm	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
<b>PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES</b>					
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>					
1.00	Inpatient hospital/SNF/NF services		358,723		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)		358,723	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)		358,723	0	7.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>					
<b>Reasonable Charges</b>					
8.00	Routine service charges		0		8.00
9.00	Ancillary service charges		757,233	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		757,233	0	12.00
<b>CUSTOMARY CHARGES</b>					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		757,233	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		398,510	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of Teaching Physicians (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		358,723	0	21.00
<b>PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.</b>					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		358,723	0	29.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		358,723	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)		358,723	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		358,723	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)		358,723	0	40.00
41.00	Interim payments		358,723	0	41.00
42.00	Balance due provider/program (line 40 minus 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2		0	0	43.00

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

Provider CCN: 151308

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

Worksheet G

Date/Time Prepared:  
11/22/2013 12:50 pm

	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	1.00	2.00	3.00	4.00	
<b>CURRENT ASSETS</b>					
1.00 Cash on hand in banks	1,488,575	10,030	0	0	1.00
2.00 Temporary investments	0	0	0	0	2.00
3.00 Notes receivable	0	0	0	0	3.00
4.00 Accounts receivable	5,156,459	0	0	0	4.00
5.00 Other receivable	617,680	0	0	0	5.00
6.00 Allowances for uncollectible notes and accounts receivable	-2,806,543	0	0	0	6.00
7.00 Inventory	195,976	0	0	0	7.00
8.00 Prepaid expenses	191,609	0	0	0	8.00
9.00 Other current assets	0	0	0	0	9.00
10.00 Due from other funds	0	0	0	0	10.00
11.00 Total current assets (sum of lines 1-10)	4,843,756	10,030	0	0	11.00
<b>FIXED ASSETS</b>					
12.00 Land	457,300	0	0	0	12.00
13.00 Land improvements	537,417	0	0	0	13.00
14.00 Accumulated depreciation	-326,403	0	0	0	14.00
15.00 Buildings	13,614,722	0	0	0	15.00
16.00 Accumulated depreciation	-6,154,403	0	0	0	16.00
17.00 Leasehold improvements	5,835,904	0	0	0	17.00
18.00 Accumulated depreciation	-4,708,078	0	0	0	18.00
19.00 Fixed equipment	2,515,125	0	0	0	19.00
20.00 Accumulated depreciation	-1,792,811	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	6,532,753	0	0	0	23.00
24.00 Accumulated depreciation	-5,300,446	0	0	0	24.00
25.00 Minor equipment depreciable	76,115	0	0	0	25.00
26.00 Accumulated depreciation	-75,671	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)	11,211,524	0	0	0	30.00
<b>OTHER ASSETS</b>					
31.00 Investments	13,796,374	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	2,037,643	37,848	0	0	34.00
35.00 Total other assets (sum of lines 31-34)	15,834,017	37,848	0	0	35.00
36.00 Total assets (sum of lines 11, 30, and 35)	31,889,297	47,878	0	0	36.00
<b>CURRENT LIABILITIES</b>					
37.00 Accounts payable	588,998	0	0	0	37.00
38.00 Salaries, wages, and fees payable	1,736,326	0	0	0	38.00
39.00 Payroll taxes payable	0	0	0	0	39.00
40.00 Notes and loans payable (short term)	14,974	0	0	0	40.00
41.00 Deferred income	0	0	0	0	41.00
42.00 Accelerated payments	0	0	0	0	42.00
43.00 Due to other funds	1,756,402	0	0	0	43.00
44.00 Other current liabilities	2,353,523	0	0	0	44.00
45.00 Total current liabilities (sum of lines 37 thru 44)	6,450,223	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>					
46.00 Mortgage payable	0	0	0	0	46.00
47.00 Notes payable	11,695,265	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)	11,695,265	0	0	0	50.00
51.00 Total liabilities (sum of lines 45 and 50)	18,145,488	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>					
52.00 General fund balance	13,743,809	0	0	0	52.00
53.00 Specific purpose fund	0	47,878	0	0	53.00
54.00 Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00 Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00 Governing body created - endowment fund balance	0	0	0	0	56.00
57.00 Plant fund balance - invested in plant	0	0	0	0	57.00
58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00 Total fund balances (sum of lines 52 thru 58)	13,743,809	47,878	0	0	59.00
60.00 Total liabilities and fund balances (sum of lines 51 and 59)	31,889,297	47,878	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151308

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

Worksheet G-1

Date/Time Prepared:  
11/22/2013 12:50 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		10,945,945		39,909		1.00
2.00 Net income (loss) (from wkst. G-3, line 29)		2,898,912				2.00
3.00 Total (sum of line 1 and line 2)		13,844,857		39,909		3.00
4.00 DEFERRED PENSION COST	0		0		0	4.00
5.00 DONATIONS	0		38,404		0	5.00
6.00 RELEASED OPERATING	25,950		0		0	6.00
7.00 OTHER	0		37,590		0	7.00
8.00 ROUNDING	2		0		0	8.00
9.00	0		0		0	9.00
10.00 Total additions (sum of line 4-9)		25,952		75,994		10.00
11.00 Subtotal (line 3 plus line 10)		13,870,809		115,903		11.00
12.00 TRANSFERS FROM AFFILIATES	115,295		0		0	12.00
13.00 OTHER PENSION RELATED NET ASSET	5,966		0		0	13.00
14.00 OTHER	5,739		0		0	14.00
15.00 RELEASED CAPITAL	0		25,950		0	15.00
16.00 RELEASED OPERATING	0		42,074		0	16.00
17.00 ROUNDING	0		1		0	17.00
18.00 Total deductions (sum of lines 12-17)		127,000		68,025		18.00
19.00 Fund balance at end of period per balance sheet (line 11 minus line 18)		13,743,809		47,878		19.00
	Endowment Fund		Plant Fund			
	6.00	7.00	8.00			
1.00 Fund balances at beginning of period	0		0			1.00
2.00 Net income (loss) (from wkst. G-3, line 29)						2.00
3.00 Total (sum of line 1 and line 2)	0		0			3.00
4.00 DEFERRED PENSION COST		0				4.00
5.00 DONATIONS		0				5.00
6.00 RELEASED OPERATING		0				6.00
7.00 OTHER		0				7.00
8.00 ROUNDING		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 FROM AFFILIATES		0				12.00
13.00 OTHER PENSION RELATED NET ASSET		0				13.00
14.00 OTHER		0				14.00
15.00 RELEASED CAPITAL		0				15.00
16.00 RELEASED OPERATING		0				16.00
17.00 ROUNDING		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: 151308

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

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
11/22/2013 12:50 pm

Cost Center Description	Inpatient	Outpatient	Total	
	1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>				
<b>General Inpatient Routine Services</b>				
1.00 Hospital	1,990,072		1,990,072	1.00
2.00 SUBPROVIDER - IPF				2.00
3.00 SUBPROVIDER - IRF				3.00
4.00 SUBPROVIDER				4.00
5.00 Swing bed - SNF	224,021		224,021	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)	2,214,093		2,214,093	10.00
<b>Intensive Care Type Inpatient Hospital Services</b>				
11.00 INTENSIVE CARE UNIT	0		0	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)	2,214,093		2,214,093	17.00
18.00 Ancillary services	7,744,869	51,144,105	58,888,974	18.00
19.00 Outpatient services	0	0	0	19.00
20.00 RURAL HEALTH CLINIC	0	0	0	20.00
21.00 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00 HOME HEALTH AGENCY				22.00
23.00 AMBULANCE SERVICES				23.00
24.00 CMHC				24.00
25.00 AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00 HOSPICE				26.00
27.00	0	0	0	27.00
28.00 Total patient revenues (sum of lines 17-27)(transfer column 3 to wkst. G-3, line 1)	9,958,962	51,144,105	61,103,067	28.00
<b>PART II - OPERATING EXPENSES</b>				
29.00 Operating expenses (per wkst. A, column 3, line 200)		22,958,052		29.00
30.00	0			30.00
31.00	0			31.00
32.00	0			32.00
33.00	0			33.00
34.00	0			34.00
35.00	0			35.00
36.00 Total additions (sum of lines 30-35)		0		36.00
37.00 DEDUCT (SPECIFY)	0			37.00
38.00	0			38.00
39.00	0			39.00
40.00	0			40.00
41.00	0			41.00
42.00 Total deductions (sum of lines 37-41)		0		42.00
43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to wkst. G-3, line 4)		22,958,052		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 151308

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

Worksheet G-3

Date/Time Prepared:  
11/22/2013 12:50 pm

		1.00	
1.00	Total patient revenues (from wkst. G-2, Part I, column 3, line 28)	61,103,067	1.00
2.00	Less contractual allowances and discounts on patients' accounts	36,246,980	2.00
3.00	Net patient revenues (line 1 minus line 2)	24,856,087	3.00
4.00	Less total operating expenses (from wkst. G-2, Part II, line 43)	22,958,052	4.00
5.00	Net income from service to patients (line 3 minus line 4)	1,898,035	5.00
<b>OTHER INCOME</b>			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	571,219	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	72,526	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	49,562	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	23,170	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISC	58,414	24.00
24.01	GRANTS	6,035	24.01
24.02	NET ASSETS RELEASED FROM RESTRICTION	42,074	24.02
24.03	MEDICAID EHR INCENTIVE	271,008	24.03
24.04	UNREALIZED GAINS	361,957	24.04
25.00	Total other income (sum of lines 6-24)	1,455,965	25.00
26.00	Total (line 5 plus line 25)	3,354,000	26.00
27.00	RESTRUCTURING & OTHER NON RECURRING	455,088	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	455,088	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	2,898,912	29.00

CMS 339 Questionnaire - Exhibit 1  
 Date Prepared: 11/22/2013 3:09:52 PM  
 Data File: X:\HFSdata\clients\Hospital\St Vincent\Mercy\28650-13.mcrx  
 Fiscal Year: 07/01/2012 To 06/30/2013  
 Provider Name: ST. VINCENT MERCY HOSPITAL  
 Provider No: 151308

Health Financial Systems  
 MCRIF32

**Allocation of Physician Compensation: Hours**  
**Department:** EMERGENCY DEPARTMENT  
**Physician:** AGGREGATE  
**Provider:** ST. VINCENT MERCY HOSPITAL  
**Number:** 151308  
**Specialty:** EMERGENCY MEDICINE-GENERAL

**Basis of Allocation:** Time Study **Describe:**

Services	Total Hours
1. Provider Services - Teaching and Supervision of I/R's and other GME Related Functions.	0.00
1A. Provider Services - Teaching and Supervision of Allied Health Students.	0.00
1B. Provider Services - Non Teaching Reimbursable Activities such as Department Administration, Supervision of Nursing, and Technical Staff, Utilization Review, etc.	0.00
1C. Provider Services - Emergency Room Physician Availability (Do not include minimum guarantee arrangements for Emergency Room Physicians.)	7416.00
1D. Sub-Total - Provider Administrative Services (Lines 1, 1A, 1B, 1C.)	7416.00
2. Physician Services: Medical and Surgical Services to Individual Patients.	1344.00
3. Non-Reimbursable Activities: Research, Teaching of I/R's in Non-Approved Programs, Teaching and Supervision of Medical Students, Writing for Medical Journals, etc.	0.00
4. Total Hours (Lines 1D, 2, and 3)	8760.00
5. Professional Component Percentage (Line 2 / Line 4)	15.34 %
6. Provider Component Percentage - (Line 1D / Line 4)	84.66 %

Signature: Physician or Physician Department Head

Date

v7

Date Prepared: 11/21/2013 6:02:18 PM

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

Provider Name: ST. VINCENT MERCY HOSPITAL

Health Financial Systems

Provider No: 151308

MCRIF32

**Allocation of Physician Compensation: Hours**

**Provider:** ST. VINCENT MERCY HOSPITAL

**Department:** ADULTS & PEDIATRICS

**Number:** 151308

**Physician:** AGGREGATE

**Specialty:** INTERNAL MEDICINE-GENERAL

**Basis of Allocation:** Time Study

**Describe:**

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

Signature: Physician or Physician Department Head

Date

v7

CMS 339 Questionnaire - Exhibit 1  
 Date Prepared: 11/21/2013 6:02:25 PM  
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 Fiscal Year: 07/01/2012 To 06/30/2013  
 Provider Name: ST. VINCENT MERCY HOSPITAL  
 Provider No: 151308

Health Financial Systems  
 MCRIF32

**Allocation of Physician Compensation: Hours**      **Provider:** ST. VINCENT MERCY HOSPITAL  
**Department:** RADIOLOGY      **Number:** 151308  
**Physician:** AGGREGATE      **Specialty:** RADIOLOGY-GENERAL

**Basis of Allocation:** Time Study      **Describe:**

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

Signature: Physician or Physician Department Head

Date

v7

CMS 339 Questionnaire - Exhibit 1  
 Date Prepared: 11/21/2013 6:02:31 PM  
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 Fiscal Year: 07/01/2012 To 06/30/2013  
 Provider Name: ST. VINCENT MERCY HOSPITAL  
 Provider No: 151308

Health Financial Systems  
 MCRIF32

**Allocation of Physician Compensation: Hours**      **Provider:** ST. VINCENT MERCY HOSPITAL  
**Department:** ONCOLOGY      **Number:** 151308  
**Physician:** AGGREGATE      **Specialty:** ONCOLOGY-GENERAL

**Basis of Allocation:** Time Study      **Describe:**

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

Signature: Physician or Physician Department Head

Date

v7

CMS 339 Questionnaire - Exhibit 1  
 Date Prepared: 11/21/2013 6:02:36 PM  
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 Fiscal Year: 07/01/2012 To 06/30/2013  
 Provider Name: ST. VINCENT MERCY HOSPITAL  
 Provider No: 151308

Health Financial Systems  
 MCRIF32

<b>Allocation of Physician Compensation: Hours</b>	<b>Provider:</b>	ST. VINCENT MERCY HOSPITAL
<b>Department:</b> SLEEP LAB	<b>Number:</b>	151308
<b>Physician:</b> AGGREGATE	<b>Specialty:</b>	INTERNAL MEDICINE-GENERAL

**Basis of Allocation:** Time Study **Describe:**

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

\_\_\_\_\_  
 Signature: Physician or Physician Department Head

\_\_\_\_\_  
 Date

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